

2009

The “Other” Intermediaries: The Increasingly Anachronistic Immunity of Managing General Agents and Independent Claims Adjusters

Jeffrey W. Stempel

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Recommended Citation

Stempel, Jeffrey W., "The “Other” Intermediaries: The Increasingly Anachronistic Immunity of Managing General Agents and Independent Claims Adjusters" (2009). *Connecticut Insurance Law Journal*. 55.
<https://opencommons.uconn.edu/cilj/55>

CONNECTICUT INSURANCE LAW JOURNAL

Volume 15, Number 2
Spring 2009



University of Connecticut School of Law
Hartford, Connecticut

Connecticut Insurance Law Journal (ISSN 1081-9436) is published at least twice a year by the Connecticut Insurance Law Journal Association at the University of Connecticut School of Law. Periodicals postage paid at Hartford, Connecticut. Known office of publication: 55 Elizabeth Street, Hartford, Connecticut 06105-2209. **Printing location: Western Newspaper Publishing Company, 537 East Ohio Street, Indianapolis, Indiana 46204.**

Please visit our website at <http://www.insurancejournal.org> or see the final page of this issue for subscription and back issue ordering information.

Postmaster: Send address changes to Connecticut Insurance Law Journal, 55 Elizabeth Street, Hartford, Connecticut 06105-2209.

The Journal welcomes the submission of articles and book reviews. Both text and notes should be double or triple-spaced. Submissions in electronic form are encouraged, and should be in MicrosoftTM WordTM version 97 format or higher. Citations should conform to the most recent edition of A UNIFORM SYSTEM OF CITATION, published by the Harvard Law Review Association.

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REINSURANCE: THE SILENT REGULATOR?

Aviva Abramovsky*

This article suggests that a discussion on insurance regulation should include a consideration of the effect that reinsurance may have on the behavior of insurers. The traditional types of reinsurance are reviewed, and the ability of private reinsurance contracts to produce insurer action is considered. If reinsurance is not included in a holistic examination of the field, its realities have the capacity to misdirect insurance regulatory assumptions. Moreover, reinsurance works as a source of independent and often unexamined contractual influence on insurer activity, and as a potential source of interference with regulatory proposals. Even though reinsurance is initiated by private contract, those contracts have the potential for regulatory effect sufficient to provide a positive answer to this Essay's main query: may reinsurance correctly be termed a "silent regulator"?

"The first principle of regulation is: Lawyers and politicians write rules; and markets develop ways to circumvent these rules without violating them."¹

* Associate Professor, Syracuse University College of Law. The author would like to thank the Searle Center for its generous support of this research and for the author's inclusion in its symposium. The author would like to recognize the staff of the H. Douglas Barclay Law Library at the Syracuse University College of Law for their invaluable help in producing this work.

¹ Allan H. Meltzer, *Regulatory Overkill*, WALL ST. J., Mar. 27, 2008 at A14.

I. INTRODUCTION

When evaluating the efficacy of insurance regulation, the nature and availability of reinsurance is not often considered.² Yet, as “the insurance of insurance companies”³, reinsurance should not be so quickly dismissed as irrelevant in the regulatory discussion.⁴ Just as insurance is often viewed as having a regulatory effect on insured industries, so too should reinsurance be considered as having a regulatory effect on its reinsureds.

Initially, a brief discussion of the concept of regulation is necessary. The term “regulation” commonly evokes thoughts of governmental action and visions of the regulatory state. For good or ill, thoughts of regulation are usually linked with thoughts of state power. Yet such a restrictive vision of regulation is simplistic and ignores the capacity of private institutions to regulate the activities of large swaths of social actors. This ability has led to the development of a fascinating body of literature which examines the myriad ways private or quasi-private insurance can regulate private behavior. With the concept of power not limited to overt government action alone, insurance takes its place among regulators of social behaviors with surprising force and scope. Indeed, it has been stated that “looking at twentieth century governance, it is tempting to see insurance as the sleeping giant of power.”⁵

Identifying insurance as a private regulator stems from the idea that insurance works as a mechanism to set social standards. Insurance is an

² This is not overly surprising since, as one commentator noted, “development of reinsurance in the United States has, for much of its history, gone largely unrecorded.” See William Hoffman, *Facultative Reinsurance Contract Formation, Documentation, and Integration*, 38 TORT TRIAL & INS. PRAC. L.J. 763, 777 (2002-2003).

³ See *Cont’l Cas. Co. v. Stronghold Ins. Co.*, 77 F.3d 16, 20 (2d Cir. 1996).

⁴ See Gary Marchitello, *Ignore Reinsurance at Your Peril*, RISK MGMT. MAG., Dec. 2007, at 46 (“Discounting the importance of the vital role of reinsurance in risk spreading and how the pricing, stability and capacity of reinsurance can influence the viability of one’s own direct insurance purchases can be a critical and potentially costly mismanagement.”).

⁵ See Tom Baker & Jonathan Simon, *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 12 (2002).

acknowledged gatekeeper of many economic activities, from buying a home to driving a car to executing a complex financial transaction. Some of this regulatory effect results from a direct delegation of state power by mandating the purchase of insurance as a prerequisite to such things as operating a car or entering a certain business, much, however, does not. When insurance is purchased without governmental compulsion, the nature of the obligations acquired alongside the indemnity function of insurance can be viewed as a form of “private legislation” within the regime of traditional notions of liberal governance.⁶

The corollary of the idea of insurance as private regulator of policyholders is to consider the concept of reinsurance as a source of private regulation of reinsured insurance companies. In effect, if insurance is a “sleeping giant of power”, how much more so is the power of reinsurers to affect the behavior and choices of insurers themselves? Through this vantage point, the reinsurance relationship begins to emerge as a subject requiring careful review and analysis in the regulatory context. Though purely private in origin⁷ and function,⁸ reinsurance of insurance

⁶ *Id.* at 13.

⁷ See 3 NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE: SEPARATE LINES OF INSURANCE, § 40.01, at 6 (2007) (“The reinsurance relationship is evidenced by a written contract reflecting the negotiated terms. Although reinsurance contracts between different cedents and reinsurers can include clauses with similar purposes, the wording of particular provisions varies significantly, depending on the parties’ specific needs, customs and practices.”).

⁸ See ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 142(d), at 1021 (4th ed. 2007) (“In many respects, the relationship between primary insurer and reinsurer tracks that of the original insured and the primary insurer. The primary insurer and reinsurer have a duty to deal with each other in good faith, and the reinsurer will have available to it the defense of misrepresentation, breach of warranty, fraud, or concealment in circumstances where the primary insurer’s acts or neglect give rise to the defense.”). See also STEVEN PLITT, ET AL., 1A COUCH ON INSURANCE § 9:17 (3d ed. 2008) (“Duties of good faith and fair dealing run between the reinsurer and the reinsured much as they do between the initial insured and his or her insurer. This duty originates from the reinsurer’s need to rely upon and not duplicate the reinsured’s efforts in properly evaluating risks and handling claims, reducing costs for both parties to the reinsurance contract. Accordingly, this duty requires the reinsured to disclose to the reinsurer all material facts which may affect the subject risk. The extension of this duty of good faith is the related

policies is common practice of the domestic insurance industry.⁹ For reasons described below, the benefits of reinsurance to an insurer are manifold¹⁰ and the likelihood that an insurer will seek reinsurance at some point great.¹¹ Hence the function of this Essay: to determine whether

concept that reinsurers are generally bound by the reinsured's good faith decision to pay a claim, commonly referred to as the 'follow the settlements' doctrine.").

⁹ Though reinsurance agreements may use any language the parties may choose to effectuate their agreements, commonly found reinsurance clauses abound. See BARRY OSTRAGER & THOMAS NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 15.03(b), at 997 (12th ed. 2003) ("Reinsurance treaties may contain 'follow the fortunes,' 'errors and omissions,' 'notice,' 'arbitration,' 'claims cooperation,' 'salvage and subrogation,' 'allocation of expenses,' 'extra contractual obligations,' 'punitive damages' and/or 'cut through clauses.' The wording of these clauses in different reinsurance certificates and treaties can also vary substantially.").

¹⁰ See REINSURANCE ASSOCIATION OF AMERICA, Fundamentals of Property and Casualty Reinsurance 4 (2009) <http://www.reinsurance.org/files/public/07FundamentalsandGlossary1.pdf> ("Reinsurance provides protection against catastrophic loss in much the same way it helps stabilize an insurer's loss experience. Insurers use reinsurance to protect against catastrophes in two ways. First, reinsurance protects against catastrophic financial loss resulting from a single event, such as the total fire loss of a large manufacturing plant. Second, reinsurance also protects against the aggregation of many smaller claims resulting from a single event, such as an earthquake or major hurricane, that affects many policyholders simultaneously. While the insurer is able to cover losses individually, the aggregate may be more than the insurer wishes to retain.").

¹¹ See Anna Walker, *Harnessing the Free Market: Reinsurance Models for FDIC Insurance Pricing*, 18 HARV. J. L. & PUB. POL'Y 735, 742-43 (1994-1995) ("Reinsurance is sought by primary insurers for various reasons. From an economic standpoint, reinsurance permits an efficient specialization of skills. In a simplified world, primary insurers are small, local, and specialized; reinsurers, on the other hand, are well capitalized international corporations with highly diversified risk portfolios. Primary insurers, because of their proximity to and knowledge of the insured, have an advantage over reinsurers in soliciting customers, pricing policies, and monitoring insureds for moral hazard. Reinsurers, on the other hand, have advantages in raising capital and diversifying and managing risk, particularly the risk of a catastrophe which might bankrupt a small private insurer. Insurers, therefore, can trade their advantages in pricing and moral hazard monitoring for the greater risk-bearing capacity of the reinsurer. Primary

reinsurance can properly be understood as a little acknowledged and “silent regulator” of the insurance industry.

To that end, Section II of this article will describe what reinsurance is and why insurers seek it. Section III will explore the main purposes of reinsurance. Section IV will review various ways reinsurance has the capacity to influence certain insurance industry behaviors. This will include a review of reinsurance’s effects on reinsured’s underwriting and claims handling practices, along with a discussion of general consumer protection issues. Section V will offer a conclusion.

Before beginning that discussion, it is important to note that insurance is not, of course, an unregulated industry, though it is the only major financial industry regulated primarily at the state level. State regulators coordinate their efforts through the highly competent National Association of Insurance Commissioners (NAIC).¹² Moreover, these state regulators share identifiable and reasonably identical goals in the performance of their duties. Among these are the promotion of competitive and sound insurance markets and the enforcement of insurance laws to assure consumers of fair treatment and protection from unfair trade practices¹³ Throughout the course of this Essay, therefore, mention will be

insurers also may find reinsurance necemeeting regulatory restrictions that limit exposure to any individual risk. By retaining only a portion of each insured risk, the insurer is able to insure a greater variety of risks with the same amount of capital, assuming that state regulators permit it to subtract reinsured risk from its reserve requirements.”).

¹² See National Association of Insurance Commissioners, <http://www.naic.org/> (last visited Feb. 11, 2009).

¹³ Insurance regulatory interests include the perennial issues of risk containment and default. However, risk of default is not the sole purview of insurance regulation. Included in regulatory efforts are issues of political interest, such as guaranteeing equitable access to insurance, and other redistributive and equitable normative policies. For example, the Connecticut Department of Insurance describes its mission as follows:

The mission of the Connecticut Insurance Department is to serve consumers in a professional and timely manner by providing assistance and information to the public and to policy makers, by regulating the insurance industry in a fair and efficient manner which promotes a competitive and financially sound insurance market for

made of reinsurance's potential as a source of support or hindrance to insurance regulatory interests. Such review gains added importance with the recognition that, other than as regards some issues of solvency, the reinsurance industry is generally unregulated at all.¹⁴

II. REINSURANCE: WHAT IS IT AND WHY HAVE IT?

At its most reductive, reinsurance is a relatively straightforward financial transaction by which an insurance company is indemnified for all or a portion of some risk by another insurer.¹⁵ This risk transfer, just as with common consumer or commercial insurance policies, is effectuated by contract, with the reinsurance agreement mainly subject to ordinary contract rules and doctrine. Some practices of reinsurance contract interpretation are distinct from the practices used in interpreting a more common insurance policy, but at this juncture it is sufficient to recognize that reinsurance is a creature of contract.¹⁶

consumers, and by enforcing the insurance laws to ensure that consumers are treated fairly and are protected from unfair practices.

Connecticut Department of Insurance: Our Mission Statement (Aug. 25, 2008), <http://www.ct.gov/cid/cwp/view.asp?q=254396>.

¹⁴ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 13 ("Since reinsurance regulation focuses on solvency, it safeguards the validity of reinsurance policies and, at the same time, maintains flexibility in the business of reinsurance. By focusing on the reinsurer, rather than on the reinsurance contract, primary insurance companies are allowed to purchase reinsurance to suit their particular business needs. Of course, reinsurance contracts are entered into by two or more insurance companies – the reinsurer(s) and the insurer(s). Recognizing that there are always some exceptions to the rule, the two companies are generally expected to be knowledgeable about the insurance business. *Therefore, the oversight necessary in primary insurance to protect consumer interests is not essential in the reinsurance business.*") (emphasis added).

¹⁵ See JERRY, *supra* note 9, § 140(a), at 1015 ("Reinsurance is essentially a form of insurance for insurance companies.").

¹⁶ PLITT, *supra* note 9, § 9:6. ("Although some rules of construction do not apply to contracts in the reinsurance context, the general rules of contract do apply to reinsurance contracts.").

A. WHAT IS REINSURANCE?

Perhaps the most difficult aspect of the study of reinsurance stems from the particularly opaque and obscure language endemic to the industry.¹⁷ Some discussion of terms is necessary. As reinsurance involves a minimum of two insurance companies, different terms have developed to identify the various parties.¹⁸ The original insurer who acquired the risk or liability is referred to by a variety of designations, including that of direct or initial insurer and sometimes, though less commonly, as the primitive insurer.¹⁹ However designated, once it has entered into an agreement with a new insurer for the purpose of reinsurance, the original insurer is thereafter most commonly referred to as the reinsured.²⁰ Though that seems clear enough, the original insurer is frequently referred to by another more exotic definition, that of cedent.²¹ This designation stems from the idea that the function of reinsurance is for the original insurer to “cede” a certain amount of its business to the reinsurer, hence the term *cedent*.²²

¹⁷ See JERRY, *supra* note 9, § 140(a), at 1015 (“The business of reinsurance has developed some special terminology.”). See also NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, § 40.01, at § 40.05 (2007) (“Reinsurance, like many areas of business law, has a language of its own.”).

¹⁸ See PLITT, *supra* note 8, § 9:2 (“There are two parties to a reinsurance agreement, but these parties have been bestowed with multiple names which are used interchangeably and are all accurate.”).

¹⁹ See GRAYDON S. STARING, THE LAW OF REINSURANCE § 1:1, at 3 (Supp. 2008) (“The original insurer, sometimes called the direct, or initial, insurer, and occasionally the primitive insurer, is commonly called the reinsured or, especially in England, the reassured.”).

²⁰ See OSTRAGER, *supra* note 10, § 15.01(c), at 992 (noting a ceding insurer or reinsured is “the insurer that transfers all or a portion of the risk it underwrites to a reinsurer.”).

²¹ See STARING, *supra* note 20, § 1:1, at 3 (“The reinsured is said to cede business to the reinsurer, or reassurer, and is therefore also referred to as the ceding company or the cedent (or cedant).”). See also NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, § 40.01 (“The insurance company purchasing reinsurance is called the ‘ceding company’ (or the ‘cedent’ (or ‘cedant’), ‘reinsured’ or ‘ceding insurer’) because it ‘cedes’ or transfers part of the risk.”).

Likewise, a reinsurer may itself seek reinsurance, called retrocessions, in the same forms and for the same purposes as any other insurers.²³ Hence, the reinsurer of a reinsurer is often called a retrocessionaire.²⁴

As a descriptive matter, reinsurance is inherently a contract of insurance, albeit a secondary one.²⁵ Reinsurance is commonly defined as a contract “by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance.”²⁶ More generally,

²² See JERRY, *supra* note 9, § 140[a], at 1054 (“The act of transferring the risk is called ‘ceding,’ and the portion of the risk passed to the reinsurer is called the ‘cession.’”).

²³ See PLITT, *supra* note 9, § 9:3 (The retrocessional agreement, like any other reinsurance agreement, is a contract and will be effective according to its terms. These terms need not mirror the specific risks of the reinsurance agreement which it is reinsuring. As can quickly be deduced, with the expansion of the insuring scenario from one to three or more separate agreements, all of which may cover different risks and have different exclusions, the resolution of indemnity responsibility can easily become complex).

²⁴ The preponderance of French terminology likely arises from the early statutory action by the French Courts in the reinsurance business. For instance, notice of the 1681 Ordonnance de la Marine of Louis XIV provided that:

The insurers may reinsure with others the effects they may have insured, and the insured may likewise cause to be insured the premium of insurance, and the solvency of the insurers.

STARING, *supra* note 20, § 1:4, at 6 (providing translation of Article XX, Title Sixth of the 1681 Ordonnance).

²⁵ PLITT, *supra* note 9, § 9:1 (“Reinsurance is a contract whereby one insurer transfers or ‘cedes’ to another insurer all or part of the risk it has assumed under a separate or distinct policy or group of policies in exchange for a portion of the premium . . . While reinsurance technically qualifies as insurance, it is a contract for indemnity rather than liability.”).

²⁶ See STARING, *supra* note 20, § 1:1, at 2 (This definition allows for the inclusion of both an existing policy or contract of reinsurance and assumes that the requirements of the contract are met. A “reinsurance policy” can therefore simply be understood as a “contract for indemnity one insurer makes with another to protect the insurer from risks already assumed.” Likewise a treaty looking forward

reinsurance includes all contractual arrangements where one insurance company transfers to another all or some portion of the risk it underwrites to another insurer.²⁷ Thus, the common refrain that reinsurance is insurance for insurance companies.²⁸

One of the hardships in understanding reinsurance is that the term is sometimes used over-broadly and applied to relationships which are best understood as something other than a commonly accepted definition of reinsurance.²⁹ Reinsurance is best understood as distinct from co-

to reinsure would constitute reinsurance, though such agreement may be better understood as a contract for reinsurance, rather than a contract of reinsurance. In either case, reinsurance policies, reinsurance treaties on specific classes of risk and reinsurance treaties entered into for future acquired risk would all come within the heading of reinsurance); OSTRAGER & NEWMAN, *supra* note 10, § 15.01, at 990.

²⁷ See *Colonial Am. Life Ins. Co. v. Comm’r*, 491 U.S. 244 (1989); OSTRAGER & NEWMAN, *supra* note 10, § 15.01[a], at 990.

²⁸ See *Cont’l Cas v. Stronghold Ins. Co., Ltd., et al.*, 77 F.3d 16, 17, 20 (2d Cir. 1996). In that case, the Second Circuit offered an additional colorful and intuitive explanation of reinsurance adopted in a New York Court of Appeals decision of the late 1930’s. See *id.* at 17. (discussing *People ex. rel. Sea Ins. Co. v. Graves*, 274 N.Y. 312, 15 (1937)) (The concept of reinsurance “dates back to the time the first bookie, fearful that he could not cover all his bets in the event he were to lose, decided to spread his risk ‘laying-off’ the risk by getting other bookies to share his exposure.”). Though colorful, that assessment is not entirely accurate. The earliest recordings of the use of reinsurance likely predated the iteration of the modern bookie and has been historically identified as predating the 17th century. See STARING, *supra* note 20, § 1:4, at 5-6 (“The earliest recorded instance is said to have been a policy written on a voyage from Genoa to Sluys and reinsured for the more hazardous portion, from Cardiz to Sluys, the insurer retaining the Mediterranean portion of the risk.”). The New York courts were not altogether mistaken as England likely recognized the relationship between insurance and speculation in the 18th Century and prohibited marine reinsurance by the Marine Act of 1745. Addressing that Parliamentary Act, Lord Mansfield noted that, “The statute doubtless was intended to prevent gambling. I suppose that the mischief was that policies were underwritten at one premium and reassurance affected at another.” *In Re Norwich Equitable Fire Assurance Soc’y* 57 LT REP. 241, 243 (1887).

²⁹ See JERRY, *supra* note 9, § 140[a], at 1053 (“Reinsurance should not be confused with the situation where one insured takes out two or more policies covering the same risk with two or more insurers. Also, reinsurance should not be

insurance, the proper term for the relationship which forms when separate insurers, either jointly or severally, assume direct shares of a given risk; in such cases where all the insurers have a direct relationship with the insured, the relationship is not within the traditional understanding of reinsurance.³⁰ Likewise, reinsurance should be distinguished from banking even though it may assist in the reinsured's financing and allow for insurance loss amortization.³¹

In a true reinsurance contract, the risk indemnified is the risk that the insurer will have to pay on the underlying insured risk.³² Reinsurance is an aspect of insurance and, to the extent that it is regulated at all, is regulated under the rubric of insurance. By entering into a contract to reinsure, the reinsurer agrees to indemnify the ceding insurer for any liability incurred by the insurer that is covered by the reinsurance

confused with the situation where the insured cancels one policy and substitutes another for it . . . Reinsurance only exists where a primary insurer becomes a 'reinsured' by entering into a contract with another insurer, the 'reinsurer.'").

³⁰ See STARING, *supra* note 20, § 1:5, at 9-10 ("Reinsurance is not coinsurance, which is the relationship that results when separate insurers, either severally or jointly, assume direct shares of a given risk; in that case, all the insurers have a direct contract with the insured. It also is not a partnership, co-venture, or syndication, even though the contract may contain clauses creating or permitting joint responsibilities or control, as well as joint loss, since true reinsurance lacks essential characteristics of those relationships.").

³¹ *Id.* at 10 ("Neither is reinsurance banking, although it performs a function of banking by providing the amortization of insurance losses and may, in effect, finance the growth of the reinsured.").

³² Risk is transferred by a variety of financial transactions, not all, or even most of which, constitute insurance. Though insurance itself remains a somewhat elusive definitional concept, the indemnity function, particularly when combined with some aspect of fortuity is often seen as core insurance principles. See PLITT, *supra* note 9, § 9:24. ("Because the reinsurance agreement is a contract of indemnity, the liability of the reinsurer is inextricably tied to the loss of the reinsured."); OSTRAGER & NEWMAN, *supra* note 10, § 15.01[a], at 990; *Travelers Indem. Co. v. Scor Reins. Co.*, 62 F.3d 74, 76 (2d Cir. 1995) (Reinsurance is generally understood as a contract for indemnity not one of liability); *Transcont'l Underwriters Agency v. Am. Agency Underwriters*, 680 F.2d 298, 299 n.2 (3d Cir. 1982).

agreement.³³ Importantly for our later discussions, the liabilities covered under a reinsuring agreement can extend beyond the cost of direct losses accrued by the cedent insurer's policyholder under the original policy to include such things as the cedent's costs of investigation and settlement of claims.³⁴ Examples of other potentially indemnified insurer losses can even include losses arising from the reinsured's own bad faith – such as “judgments in excess of loss” costs and extracontractual, tortious bad faith liability.³⁵

B. A BRIEF TAXONOMY OF REINSURANCE

As reinsurance is a contractual arrangement, the nature, complexity and terms of many contracts stray from the standardization common among primary insurance policies.³⁶ In fact, because of reinsurance's remarkable flexibility and its capacity to take on a large variety of risk types and risk levels, the policies vary in their purposes and specifics.³⁷ The terms of the reinsurance contract and the terms of the policies reinsured determines the scope of the indemnity offered by the reinsurer.³⁸ The contracts reflect the business needs of sophisticated commercial entities and, as such, the terms,

³³ PLITT, *supra* note 9, § 9:24 (“It is the language of the reinsurance contract that will ultimately determine the extent of the reinsurer's liability to the reinsured. In other words, the sustaining of a loss by the original insured cannot create liability for the reinsurer extending beyond the terms of its contract”). *See also* STARING, *supra* note 20, § 15:1, at 1 (“It does not necessarily follow that, where the first insurer is liable, the reinsurer is also liable. Whether or not the reinsurer is liable depends upon the terms of the contract of reinsurance.”).

³⁴ *See* PLITT, *supra* note 9, § 9:30.

³⁵ *See* OSTRAGER & NEWMAN, *supra* note 10, § 16.06[a], at 1045-1048.

³⁶ *See id.* § 15.03[b], at 997 (“Reinsurance treaties and certificates vary considerably in their language and terms of coverage”).

³⁷ *Id.* (“Reinsurance treaties may contain ‘follow the fortunes,’ ‘errors and omissions,’ ‘notice,’ ‘arbitration,’ ‘claims cooperation,’ ‘salvage and subrogation,’ ‘allocation of expenses,’ ‘extra contractual obligations,’ ‘punitive damages’ and/or ‘cut through clauses.’ The wording of these clauses in different reinsurance certificates and treaties can also vary substantially.”).

³⁸ *See* Hartford Fire Ins. Co. v. Cal., 509 U.S. 764, 806-07 (1993).

conditions and costs of a reinsurance contract are all negotiable.³⁹ Various clauses such as “follow the forms” and “follow the settlements”⁴⁰ or clauses for “extracontractual damages”⁴¹, all discussed later in further detail, are common to many reinsurance contracts. The interaction of various clauses and the reciprocal obligations of good faith will be discussed in Section IV as we review the performance standards required by the reinsurance agreement. First, in order to understand the purposes of reinsurance, we review a few of the common types of arrangements common to those agreements.⁴²

³⁹ See NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, at 40.01 (“The reinsurance relationship is evidenced by a written contract reflecting the negotiated terms. Although reinsurance contracts between different cedents and reinsurers can include clauses with similar purposes, the wording of particular provisions varies significantly, depending on the parties’ specific needs, customs and practices.”).

⁴⁰ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 31 (noting “‘follow the settlements’ generally provides that a reinsurer must cover settlements made by the reinsured in a business like manner, provided the settlement is arguably within the terms of the reinsured’s policy and the reinsurance agreement and the settlement is not affected by fraud, collusion or bad faith. It is an expectation that the reinsurer will abide by the reinsured’s good faith determination to settle, rather than litigate, claims under a reinsured policy and not relitigate a reinsured’s settlements ceded to the reinsurance agreement. The term is often used interchangeably with follow the fortunes, and there may be overlap between the affect of follow the settlements and follow the fortunes when the ‘risk’ is what generated the loss. Follow the settlements is focused on ‘loss settlement’, not necessarily tied to a ‘risk determination’ arising out of follow the fortunes.”).

⁴¹ *Id.* at 29 (noting the definition of the term extra-contractual obligations as “in reinsurance, monetary awards or settlements against an insurer for its alleged wrongful conduct to its insured. Such payments required of an insurer to its insured are extra-contractual in that they are not covered in the underlying contract.”).

⁴² See PLITT, *supra* note 9, § 9:3 (“There are two broad categories of reinsurance agreements: facultative reinsurance and treaty reinsurance.”).

i. *Facultative Reinsurance*

Facultative reinsurance is the most discrete form of reinsurance, and generally accepted as the likely original form of reinsurance.⁴³ Facultative reinsurance policies take their name because the contracts allow the reinsurance company to use its “faculties” or reason to choose to reinsure a specific risk, a specific policy, or a specific group of policies.⁴⁴ The ceding insurer and reinsurer agree to the terms and conditions of each individual contract.⁴⁵ In these contracts, the reinsurer often conducts its own underwriting to determine the appropriate premium level.⁴⁶ Facultative reinsurance contracts provide reinsurance for the unusual; they also have the greatest specific effect on the cost of covering unusual or

⁴³ See STARING, *supra* note 20, § 1:4 (“Facultative reinsurance of a single risk, which was undoubtedly the original type, continued dominant until the last half of the Nineteenth Century. A treaty, which is a long term contract covering more than one risk, is known to have existed as early as 1821. Treaties became common around the beginning of the Twentieth Century and one form, the excess of loss treaty, is said to have become widespread as a result of the San Francisco earthquake and fire of 1906”).

⁴⁴ See JERRY *supra* note 9, § 140[b], at 1054 (“Facultative reinsurance involves the primary insurer entering into an agreement for the reinsurance of a particular risk. The reinsurance can be written on a pro rata or an excess basis; the root word “faculty” denotes that the reinsurer has a choice of accepting or rejecting any risk proposed and of demanding whatever premium it thinks appropriate.”).

⁴⁵ See NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, at § 40.04[1] (“The reinsurer and cedent negotiate the terms for each facultative certificate.”). See also STARING, *supra* note 20, at §2:2 (“The prospective reinsured, either directly or through a broker, presents the direct policy terms, or a summary of them, and the proposal for reinsurance. If it is accepted at a satisfactory premium, a contract is made. Other terms are negotiated to the satisfaction of both parties.”).

⁴⁶ See STARING, *supra* note 20, § 2:6 (“The reinsurer will always have at least a general, if not a particular, interest in the integrity of the reinsured’s underwriting and claims practices.”). See also NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, § 40.04[1] (“Facultative reinsurance is commonly purchased for large, unusual or catastrophic risks. Reinsurers thus must have the necessary resources to underwrite individual risks carefully.”).

low-incidence risks.⁴⁷ Likewise, with its ability to allow reinsurers to engage in significant underwriting operations prior to placing the policy, facultative reinsurance is often used to cover catastrophic or other low incidence – high loss risks.⁴⁸ Individual risk facultative reinsurance may be used in tandem with the second variety of reinsuring agreements, the treaty.⁴⁹

ii. *Treaty Reinsurance*

Treaties are broad agreements that reinsure multiple contracts, often contracts that have yet to be written by the direct insurer.⁵⁰ Usually, treaties cover some portion or class of business of the direct insurer and historically may cover a long period of time, usually renewable on a fairly automatic basis unless one of the parties seeks a new term.⁵¹ Treaties are

⁴⁷ See STARING, *supra* note 20, § 2:3, at 4 (“Once, no doubt, all reinsurance was facultative. With the rise of treaties, they account for great amounts of reinsurance but facultative reinsurance, which requires individual attention to underwriting, remains very important for businesses that fall outside the bounds of a treaty reinsurance program. The reinsured may want to meet competition and enter into new lines in which it has no expertise but can gain it through initially taking risks and obtaining facultative reinsurance from those who have experience. The reinsured may need facultative reinsurance where the risk falls under an exclusion in its treaties, either as to type or amount, or because the risk, although routine in nature, present a very high loss exposure. In the end, all these uses serve the general purpose of reinsurance to provide stability and promote growth.”).

⁴⁸ See OSTRAGER & NEWMAN, *supra* note 10, § 15.01[b] (“The availability of reinsurance enables an insurer to accept risks that would otherwise be beyond its underwriting capacity by allowing the ceding insurer to ‘lay-off’ on reinsurers a portion of the risk of loss. Thus, reinsurance enables insurers to spread the risk of catastrophic losses among a larger pool of insurers.”).

⁴⁹ See New Appleman Insurance Law Practice Guide, *supra* note 8, at § 40.04[1].

⁵⁰ JERRY *supra* note 9, § 140[b], at 1054.

⁵¹ *Id.* (“Most reinsurance is treaty reinsurance. The treaty arrangement, sometimes called “automatic reinsurance,” involves a commitment of a reinsurer to assume part of the risk of the primary insurer, either on a pro rata or an excess basis, for a stated period.”).

particularly useful reinsuring mechanisms since they can be structured to reinsure losses on direct insurance which either were written during the term of the treaty but occur later, or they can be structured to reinsure losses that occur during the term of treaty but were written earlier.⁵² Likewise, the premiums may be calculated in a variety of ways including structuring the reinsurance premium in some way directly related to the premiums on the underlying policies or assigning a single sum or some other variable amount as the parties wish and which reflect their business purposes.⁵³ Generally speaking, the treaty reinsurance contract forms when the original insurer cedes part of the premiums for its policies and the risk of losses on those policies to the reinsurer.⁵⁴ Treaty reinsurance usually involves multiple reinsurers taking part of a book of the business' risks, with each agreeing to assume a portion of the risk in some pre-determined manner.⁵⁵

Importantly, reinsurance treaties cover all risks written by the reinsured that fall within their terms unless specifically excluded.⁵⁶ For this reason, treaty reinsurers generally do not review the individual risks underlying the treaty and do not conduct their own underwriting of the

⁵² See STARING, *supra* note 20, § 2:4, at 4-5.

⁵³ *Id.* at 5 (“Depending again on its structure and purpose, the premiums may be directly related to the premiums on the underlying insurance or may be lump sums, or variable amounts, not based on direct participation in the underlying premiums.”).

⁵⁴ OSTRAGER & NEWMAN, *supra* note 10, § 15.03[a], at 996. (“The reinsurer, under a single contract, agrees to indemnify the ceding insurer with respect to an entire ‘book’ of the ceding insurer’s underwriting activities for designated lines of insurance. A treaty reinsurance contract is formed when the primary insurer cedes part of the premiums for its policies and the losses on those policies to a reinsurer.”).

⁵⁵ *Id.* (“Arrangements typically involve the participation of numerous reinsurers, each agreeing to assume a percentage of the total liability under a single treaty.”).

⁵⁶ See NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, § 40.04, at 17. (“Reinsurance treaties cover all of the risks written by the ceding insurer that fall within their terms unless exposures are specifically excluded. Thus, in most cases, neither the cedent nor the reinsurer has the ‘faculty’ to exclude from a treaty a risk that fits within the treaty terms.”).

risks.⁵⁷ Rather, they rely on the underwriting experience of the original insurer, with a prudent reinsurer investigating the underwriting philosophy, loss experience, attitude towards claims management and other business practices.⁵⁸ Facultative reinsurance can be combined with treaty reinsurance to cover exclusions in the treaty or for other business purposes, some of which we explore later.⁵⁹

iii. *The Verticals and Horizontals of Reinsurance: Pro-rata and Excess of Loss*

Again, we recognize along with the United States Supreme Court that:

In indemnity reinsurance . . . [the reinsurer] agrees to indemnify, or reimburse, the ceding company for a specified percentage of the claims and expenses attributable to claims that have been reinsured.⁶⁰

⁵⁷ *Id.* (“Treaty reinsurers rely heavily on the cedent’s underwriting.”).

⁵⁸ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 7. (“While treaty reinsurance does not require review of individual risks by the reinsurer, it demands a careful review of the underwriting philosophy, practice and historical experience of the ceding insurer, including a thoughtful evaluation of the company’s attitude toward claims management, engineering control, as well as the management’s general background, expertise and planned objectives.”).

⁵⁹ *See* REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 29, 54. (Noting the definition of treaty reinsurance is “is a reinsurance contract under which the reinsured company agrees to cede and the reinsurer agrees to assume risks of a particular class or classes of businesses” and the definition of facultative reinsurance is “reinsurance of individual risks by offer and acceptance wherein the reinsurer retains the ability to accept or reject each risk offered by the ceding company.”).

⁶⁰ *Colonial American Life Ins. Co. v. Comm’r*, 491 U.S. 244, 247 (1989). *See also* *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 806-07 (1993).

The insured's indemnification by the reinsured need not be total or complete.⁶¹ In fact, the ability of reinsurers to take only a portion of a risk or book of risks is one of the particularly useful risk spreading-elements of reinsurance.⁶² There is nothing to prevent a single reinsurer from taking all indemnity responsibility for a policy or group of policies, but most reinsuring agreements take responsibility for only a portion of those losses.⁶³ Traditionally, the responsibilities divide into two basic divisional structures most easily visualized as either a vertical or horizontal slicing up

⁶¹ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 1 ("Reinsurance is a transaction in which one insurance company indemnifies, for a premium, another insurance company against all or part of the loss that it may sustain under its policy or policies of insurance").

⁶² *Id.* ("The fundamental objective of insurance, to spread the risk so that no single entity finds itself saddled with a financial burden beyond its ability to pay, is enhanced by reinsurance."). See also NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8 ("Reinsurance relationships can be simple or complex. A cedent can cede certain loss exposures under one contract or purchase several contracts covering different aspects or portions of the same policy to achieve the desired degree of coverage. A layering process involving two or more reinsurance agreements is commonly employed to obtain sufficient monetary limits of reinsurance protection. When a claim is presented, the reinsurers respond in a predetermined order to cover the loss.").

⁶³ See PLITT, *supra* note 9, § 9:1, at 3-4 ("Reinsurance is a contract whereby one insurer transfers or 'cedes' to another insurer all or part of the risk it has assumed under a separate or distinct policy or group of policies in exchange for a portion of the premium.").

of the losses from particular risks assumed.⁶⁴ Both facultative and treaty reinsurance can be written in either a pro-rata or excess of loss basis.⁶⁵

C. PRO-RATA AND EXCESS OF LOSS

If a reinsurer does not want indemnification responsibility for an entire risk classification or group of policies, it can structure the treaty to take on only a specific portion of each risk to which it applies.⁶⁶ Using a pro-rata reinsurance contract, the reinsurer agrees to indemnify the ceding insurer for a percentage of original risk losses in exchange for a corresponding portion of the premium.⁶⁷ Generally, pro-rata agreements

⁶⁴ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 1 (“Reinsurance may be written on either a proportional basis or excess of loss basis. A reinsurance contract written on a proportional basis simply prorates all premiums, losses and expenses between the insurer and the reinsurer on a pre-arranged basis. The proportional approach is used extensively in property reinsurance. Excess of loss contracts, on the other hand, require the primary insurer to keep all losses up to a predetermined level of retention, and the reinsurer to reimburse the company for any losses above that level of retention, up to the limits of the reinsurance contract. In simplest terms, a retention is analogous to the deductible a policyholder may have on a personal insurance policy, such as an automobile or homeowner’s policy.”).

⁶⁵ See OSTRAGER & NEWMAN, *supra* note 10, §15.03[a], at 996 (“Both treaty reinsurance and facultative reinsurance can be written on either a pro-rata or excess-of-loss basis. Treaty reinsurance involves an ongoing agreement between two insurers, binding in advance one to cede and the other to accept specified business that is the subject of the treaty. Facultative reinsurance is negotiated with respect to a specific risk insured by a particular policy or policies.”). See also REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 7..

⁶⁶ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 10 (“Under proportional reinsurance, the ceding insurer and the reinsurer automatically share all premiums and losses covered by the contract on a pre-agreed basis, thus there are no characteristics uniquely attributable to the risk associated with proportional reinsurance.”).

⁶⁷ See OSTRAGER & NEWMAN, *supra* note 10, § 15.02[a], at 993 (“Pursuant to a pro-rata reinsurance contract, the reinsurer agrees to indemnify the ceding insurer for a percentage of any losses from the original risk in return for a corresponding portion of the premium for the original risk.”).

obligate the reinsurer to indemnify an insurer without requiring any retention by the reinsured.⁶⁸ Commonly, this type of pro-rata arrangement is called Quota Share Reinsurance, where the ceding company indemnifies the cedent insurer for a fixed percentage of loss on all policies of a defined risk type.⁶⁹ This easily visualized apportionment can become somewhat more complex in that a “pro-rata” treaty can also be horizontally segmented within each “slice” by requiring the ceding insurer to retain some portion of the loss with the reinsurer only responsible for the surplus.⁷⁰ This type of pro-rata reinsuring up to the amount of insurance originally written, minus the ceding insurer’s retention is commonly called Surplus Share Reinsurance.⁷¹ With the entrance of additional retrocessionaires there can be quite a bit of segmentation in this surplus line.

⁶⁸ See *Ott v. All-Star Ins. Corp.*, 299 N.W.2d 839, 843 (Wis. 1981); *Central Nat’l Ins. Co. v. Devonshire Coverage Corp.*, 426 F. Supp. 7, 11 n. 5, 21 (D. Neb. 1976), *aff’d in part and remanded*, 565 F.2d 490 (8th Cir. 1977). See also OSTRAGER & NEWMAN, *supra* note 10, § 15.02[a], at 993 (“Pro-rata reinsurance arrangements generally obligate the reinsurer to pay a proportion of any losses that occur with no retention by the reinsured.”).

⁶⁹ See JERRY, *supra* note 9, § 140[b], at 1054-1055 (“Pro rata reinsurance, sometimes called ‘quota share’ reinsurance, means that losses, premiums, and expenses are divided pro rata by the primary insurer and the reinsurer. For example, the primary insurer may retain sixty percent of the risk and transfer forty percent. If any loss occurs, whether large or small, the primary insurer is liable for sixty percent of the loss and the reinsurer is liable for forty percent.”). See also OSTRAGER & NEWMAN, *supra* note 10, § 15.02[a], at 993 (noting quota share reinsurance “indemnifies the ceding insurer for a fixed percentage of loss for all policies of a defined type written by the ceding company.”).

⁷⁰ JERRY, *supra* note 9, § 140[b] at 1055. (“A special kind of pro rata reinsurance is ‘surplus reinsurance.’ Under surplus reinsurance, the reinsurer agrees to cover a share of the risk that varies with the size of the exposure. For example, the treaty might specify that losses under \$50,000 are covered in full by the primary insurer, that the first \$50,000 of losses between \$50,000 and \$250,000 is paid by the direct insurer and the rest by the reinsurer, and that losses exceeding \$250,000 are paid 20 percent by the direct insurer and 80 percent by the reinsurer.”).

⁷¹ See OSTRAGER & NEWMAN, *supra* note 10, § 15.02[a], at 993 (noting surplus share reinsurance “indemnifies the ceding insurer for a fixed percentage of loss for all policies of a defined type written by the ceding company.”).

Another interesting aspect of pro-rata treaties is the reinsured's obligation to automatically accept its portion of the risks insured.⁷² Pro-rata treaties come in a variety of broad types, knowledge of each of which is useful for our later discussion. For instance, the treaty can be pro-rata and obligatory.⁷³ Through this structure, all risks in a specified category are shared automatically by some proportion agreed to.⁷⁴ Pro-rata treaties often allocate a portion of the original premium to the reinsurer.⁷⁵

In the excess of loss reinsurance scenario, the reinsurer's obligation is defined in relation to the reinsured's retention.⁷⁶ In this structure the reinsurer, subject to specific stated limits of coverage, indemnifies the reinsured for all or a stated portion of losses in excess of the agreed upon retention.⁷⁷ The agreements can be structured so that the reinsurance can

⁷² See NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, § 40.04[2], at 16 ("Proportional or pro-rata reinsurance is characterized by a proportional division of liability and premium between the ceding company and the reinsurer.").

⁷³ *Id.* ("The cedent pays the reinsurer a predetermined share of the premium, and the reinsurer indemnifies the cedent for a like share of the loss and the expense incurred by the cedent in its defense and settlement of claims (the 'allocated loss adjustment expense' or 'LAE'").

⁷⁴ *Id.* ("According to the percentage agreed, the cedent and reinsurer share the premium and losses from the business reinsured.").

⁷⁵ See OSTRAGER & NEWMAN, *supra* note 10, § 15.02[a], at 993 ("Pursuant to a pro-rata reinsurance contract, the reinsurer agrees to indemnify the ceding insurer for a percentage of any losses from the original risk in return for a corresponding portion of the premium for the original risk. Pro-rata reinsurance arrangements generally obligate the reinsurer to pay a proportion of any losses that occur with no retention by the reinsured.").

⁷⁶ See STARING, *supra* note 20, at 4 ("Whether the contract is pro rata or excess, the reinsured will...be expected ordinarily to retain a sufficient amount of the risk to give the reinsurer confidence that the policy will be well administered.").

⁷⁷ See *Compagnie de Reassurance d'Ile de France v. New England Reinsurance Corp.*, 944 F. Supp. 986, 998 n.17 (D. Mass. 1996).

be excess to the specific risk, specific occurrence, an aggregate dollar amount or specified loss ratio.⁷⁸

III. PURPOSES OF REINSURANCE

A comprehensive review of all the reasons an insurer may seek to reinsure is not possible or necessary for the purposes of this Essay. Suffice it to say that as reinsurance is a flexible medium and supports a variety of functions, the purpose of acquiring it will differ in accordance with the business interests of the insurer seeking it.⁷⁹ Likewise, as reinsurance serves a variety of purely financial and accounting purposes, reinsurance may be employed for purposes slightly beyond the scope of this Essay's interest in its potential regulatory effects on insurance companies as insuring companies, rather than as financial institutions. Regardless, in accordance with our focus on the potential effects of reinsurance on primary insurers, it is useful to review the four main purposes for which reinsurance is generally sought in relation to the primary insurer's insurance function.⁸⁰

⁷⁸ OSTRAGER & NEWMAN, § 15.02[b], at 994 (noting per risk or specific excess reinsurance "indemnifies the ceding insurer, subject to a specified limit, against the amount of loss in excess of a specified retention with respect to each risk covered by a reinsurance arrangement"; per occurrence reinsurance "indemnifies the ceding insurer, subject to a specified limit, against the amount of loss in excess of a specified retention with respect to each occurrence"; aggregate excess of loss reinsurance "indemnifies the ceding insurer for the amount by which the ceding insurer's loss during a specified period exceeds either (a) a specific dollar amount or (b) a percentage of the company's subject premium"; and stop loss reinsurance "indemnifies the ceding insurer for losses in excess of a specified loss ratio up to a predetermined loss ratio limit.").

⁷⁹ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 3 ("Depending on the ceding company's goals, different types of reinsurance contracts are available to bring about the desired result.").

⁸⁰ *Id.* (Insurers purchase reinsurance for essentially four reasons: (1) to limit liability on specific risks; (2) to stabilize loss experience; (3) to protect against catastrophes; and (4) to increase capacity.").

A. RISK ALLOCATION

For some purposes, reinsurance serves the almost identical purpose for the reinsured insurance company as that of many other common commercial insurances. Thus, reinsurance's initial purpose may be viewed as a basic reallocation of risk and as an additional way to spread risk.⁸¹ Just as any commercial entity might enter the insurance market seeking indemnity for specific types of loss, so too does the insurer seek a mechanism to transfer the risk it chose to underwrite to another party.⁸² In a reinsurance situation, the risk acquired by the ceding insurer transfers to the reinsurer to the extent and within the limits of the negotiated contract; to the extent that those risks are allocated among numerous reinsurers, the risk is spread even further.⁸³

This risk transfer benefits the insurer by allowing the reinsured to take action that might otherwise be prohibited or disallowed sans reinsurance.⁸⁴ For instance, through the medium of reinsurance, the ceding

⁸¹ *Id.* ("By providing a mechanism through which insurers limit their loss exposure to levels commensurate with their net assets, reinsurance enables insurance companies to offer coverage limits considerably higher than they could otherwise provide.").

⁸² *Kemper Reins. Co. v. Corcora (In re Midland Ins. Co.)*, 590 N.E.2d 1186, 1188 (1992).

⁸³ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 6. Importantly, it must be remembered that reinsurance does not actually lessen total risk exposure:

In any discussion of reinsurance, the limitations must be considered along with its advantages. Reinsurance does not change the inherent nature of a risk being insured. It cannot make a bad risk insurable or an exposure more predictable or desirable. And while reinsurance may limit an insurance company's exposure to a risk, the total risk exposure is not altered through the use of reinsurance.

Id.

⁸⁴ JERRY, *supra* note 9, § 141, at 1056 ("[R]einsurance permits an insurer to transfer large risks that it is unable to manage or that are simply too risky to another insurer.").

insurer can underwrite business that it might otherwise not have been able to undertake.⁸⁵ Either the risk itself may simply be too large or the risk of loss might be unusual in some other way.⁸⁶ By limiting their loss exposure through reinsurance, the reinsured can offer higher coverage limits than they could otherwise afford.⁸⁷ Through this mechanism, smaller insurers have the capacity to compete with larger companies and offer their policyholders a broader array of coverage options.⁸⁸

Likewise, the insurer may want to enter business lines that present the possibility of some future unexpected losses the insurer is unwilling to retain beyond a specific retention.⁸⁹ Either the possibility of a very great a

⁸⁵ *Id.* (“For example, an insurer that has a portfolio of coverage faces the risk that a large number of small losses of an unexpected, unexceptional nature may occur, thereby exceeding the insurer’s capacity to pay for them without suffering a loss.”).

⁸⁶ *Id.* (“[T]he insurer faces the risk that a single catastrophic event, the precise timing of which is uncertain (e.g., an earthquake) may occur with devastating consequences to the insurer’s balance sheet.”).

⁸⁷ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 3 (“In calculating an appropriate level of reinsurance, a company takes into account the amounts of its own available surplus, and determines its level of retention based on the amount of loss it can absorb financially. Surplus, sometimes referred to as policyholders’ surplus, is the amount by which the assets of an insurer exceed its liabilities. A company’s retention may range anywhere from a few thousand dollars to one million dollars or more. The loss exposure above the retention, up to the policy limits of the reinsurance contract, is indemnified by the reinsurer. In this manner, reinsurance helps to stabilize loss experience on individual risks, as well as on accumulated losses under many policies occurring during a specified period.”).

⁸⁸ *Id.* (noting reinsurance’s goal of limiting liability “is crucial because it allows all companies, large and small, to offer coverage limits to meet their policyholders’ needs. In this manner, reinsurance provides an avenue for small-to-medium size companies to compete with industry giants.”).

⁸⁹ JERRY, *supra* note 9, at § 141, at 1056-57 (“Just as reinsurance enables an insurer to take on new business, reinsurance can also be used to enable an insurer to leave a particular kind of business quickly. An insurer that wants to rid itself of a particular kind of coverage can solicit reinsurance for all of the insurance the carrier has written, which effectively takes the insurer out of the business and makes the reinsurer the insurer for all of the risks.”).

number of small, unexpected losses or the possibility of a single, catastrophic loss which could overwhelm the insurer's balance sheet might cause a prudent insurer to acquire reinsurance to offset the risk of loss.⁹⁰ This prudential risk-transferring purpose of reinsurance appropriately supports a decision to reinsure, even though the insurer believes (as it must) that its underwriting decisions are prudent and the premium appropriate. After all, sufficiently imprudent underwriting could well be a defense to reinsurance coverage.⁹¹ Still, even the most perspicacious of underwriters cannot foresee the unexpected; thus the prudential purpose of reinsurance.

⁹⁰ *Id.* at 1056 (“When the primary insurer purchases reinsurance, it reduces the size of its potential losses, which reduces the size of the reserves it must maintain. Insurers, however, are not as interested in reducing reserves as they are in increasing their business. An insurer with the minimum allowable level of reserves and surplus (the amount an insurer is required to maintain in excess of reserves to meet unexpected losses) could not take on new business or enter new fields. However, reinsurance provides a solution: the insurer could write the coverage, transfer the risk to a reinsurer, and receive a commission from the reinsurer. The primary insurer adds no new liabilities, but its surplus increases by the amount of the commission. This increased surplus enables the primary insurer to write and retain additional coverage. Another way to view this transaction is that some of the excess capacity of the reinsurer is utilized by the business-garnering efforts of the primary insurer; in essence some excess capacity is transferred from the reinsurer to the primary insurer. For the small insurer who wants to grow, reinsurance is an important way to take on new business beyond its means and simultaneously increase its capacity.”).

⁹¹ PLITT, *supra* note 9, at § 9:31, 80-1 (“The duty of good faith that runs between the parties to a reinsurance contract is essential to the reinsurance relationship. Stemming from the reinsurer's need to rely upon and not duplicate the reinsured's efforts in properly evaluating risks and handling claims, and reducing costs for both parties to the reinsurance contract. Due to these specific needs of the industry, the duty of utmost good faith in this context connotes a higher duty than the ordinary duty of good faith that is inherent in general contract law. Accordingly, it requires that the reinsured must disclose to the reinsurer all material facts which may affect the subject risk. The failure of a reinsured to disclose material facts to the reinsurer will warrant the rescission of a reinsurance contract.”).

B. RESERVE REQUIREMENTS

A second purpose for reinsurance, one particularly importantly in the insurance regulatory context, is using reinsurance to reduce the amount of reserves an insurer must maintain, thus freeing the insurer up to write more policies.⁹² In purchasing reinsurance, the primary insurer reduces the size of its potential losses, which allows it to reduce its statutorily mandated reserves.⁹³ Hence, if a primary insurer hits the threshold for the minimum allowable level of reserves plus surplus that it is statutorily required to maintain, the amount of new business open to it would be restricted. But, if the primary insurer purchased reinsurance, the primary would still be able to write new policies so long as it could transfer the risk to the reinsurer.⁹⁴ In fact, since the reinsurer swaps the new risk in exchange for a commission, the primary insurer is frequently seen as acquiring no new liabilities, while its surplus is viewed as increasing by the amount of the reinsurer's commission.⁹⁵ The majority of public regulation governing reinsurers concerns itself with this aspect of the reinsuring relationship.⁹⁶

⁹² See *Kemper Reins. Co. v. Corcoran (In re Midland Ins. Co.)*, 79 N.Y.2d 255, 258 (1992) (noting reinsurance allows "a primary insurer to reduce the amount of legally required reserves held for the protection of policyholders, and to increase the company's ability to underwrite other policies or make other investments").

⁹³ See *STARING*, *supra* note 20 ("For the individual insurer, the purchase of reinsurance has any or all of a number of objectives. It will desire to limit the reserves it must maintain for losses on its ordinary business.").

⁹⁴ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 4-5 ("When an insurance company issues a policy, the expenses associated with issuing that policy, such as taxes, agent commissions, and administrative expenses, are charged immediately against the company's income, resulting in a decrease in surplus. Meanwhile, the premium collected must be set aside in an unearned premium reserve to be recognized as income over a period of time. This accounting procedure allows for strong solvency regulation; however, it ultimately leads to decreased capacity. As an insurance company sells more policies, it must pay more expenses from its surplus. Therefore, the company's ability to write additional business is reduced.").

⁹⁵ *Id.* ("Insurers purchase reinsurance...to increase capacity.").

i. Regulation of Reinsurance for Purposes of Solvency

Though by no means its sole purpose, much insurance regulation exists simply to decrease the likelihood of unexpected insurance company failure. Regulators typically identify the fiscal ramifications of wide-scale insurance failure as their justification for proper insurance regulation. Therefore, though permitting reinsurers to go unregulated in other aspects, regulators recognized that the potential insolvency of a reinsurer could affect the solvency of its reinsureds, and have therefore taken legislative action to minimize that risk.

This is no idle matter. Both the Transit Casualty Company and Mission Insurance Company failed due to insurance insolvency in the 1980's.⁹⁷ The failure occurred in part because they could not collect from their reinsurers. To address this risk, the states all have various techniques in place to assure reinsurer solvency. If admitted or licensed in the state, the reinsurer must comport with certain reserve requirements of its own or, if foreign or unadmitted, states require the reinsurer to offer a bond sufficient to allay fears of not collecting on reinsurance agreements.⁹⁸ If the company does not post a bond, the insurer cannot take advantage of reinsurance's ability to grant credit and expand reserves.

⁹⁶ Since reserves are the primary way public regulators attempt to reduce the risk of insurer insolvency and default, a great amount of activity has occurred amongst and between regulators to devise statutory schemes that allow for protection of the reserves. *See, e.g.*, INVESTMENTS OF INSURERS MODEL ACT § 22 (NAIC 2007). There has been some very interesting work on reinsurer chartering and on bonding requirements for foreign insurers reinsuring domestic primaries.

⁹⁷ U.S. Gen. Accounting Office, Insurance Regulation: State Reinsurance Oversight Increased, but Problems Remain 8 (1990). [Hereinafter 1990 GAO Report].

⁹⁸ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 13 (“When overriding public policy concerns require regulatory involvement, however, nearly all states have adopted regulations affecting reinsurance contracts. An example of this type of regulatory involvement is the requirement of a standard insolvency clause, which allows the receiver of an insolvent insurer to collect on reinsurance contracts. While few states require the filing or approval of reinsurance contracts, indirect regulation of reinsurance contracts and rates does exist. For example, restrictions on insurance rates affect reinsurance rates. Generally, if the amount paid in the premium to the insurer is limited, the amount of premium paid under a quota share reinsurance contract may also be limited.”).

Still, the multi-state system leads to some fears of inadequacy and redundancy. To address these issues, along with the perennial problem of construing the appropriate way for the states to share in the taxation of these transactions, the House of Representatives in June 2007 passed HR 1065, the Nonadmitted and Reinsurance Reform Act.⁹⁹ The Senate companion bill, S 929, awaits consideration in the Senate.¹⁰⁰ That legislation would create a single state authority to determine the appropriateness of reinsurance credit and reinsurer solvency assessment.¹⁰¹ The solvency assessment would be conducted by the reinsurer's home state and the credit determination would be made solely by the ceding insurer's domiciliary state.¹⁰² It is unclear how this alters the current regulatory system other than to encourage reinsurers or insurers to change their domiciles in search of a state whose regulation best comports with their needs, though it likely will assist in clarifying taxation. In any event, these Congressional efforts reflect an understanding of reinsurance's direct effect on insurer's solvency.

By this legislative activity, it is apparent the regulators are not entirely unaware of the financial effects a reinsurer default could have on reinsureds. Yet, this type of legislation is still limited to regulation of reinsurance only as a source of funds for the domestic insurer. Basically, it reflects a conceptualization of reinsurance as a mere contractually acquired source of capital. There is no attempt in the regulatory legislation to move beyond solvency and to address the effects the terms a reinsurance agreement may have on their reinsured's performance as regards their underlying policyholders. So far as regulators appear concerned, their responsibility to regulate reinsurance ends with regulating solvency.

⁹⁹ National Association of Insurance Commissioners, Current Issues: Nonadmitted Insurance and Reinsurance, http://www.naic.org/topics/topic_surplus_lines.html (last visited February 19, 2009).

¹⁰⁰ *Id.* (That legislation would grant exclusive regulatory authority for multi-state surplus lines and to the insured's home state so as to restrict each transaction to a single set of regulatory oversight, rules and taxation).

¹⁰¹ *Id.*

¹⁰² *Id.*

C. RISK EXITS AND FRONTING

A third commonly accepted purpose of reinsurance allows the primary insurer to cease writing some policies.¹⁰³ An insurer that seeks to exit a certain risk stream can be relieved of the risks of loss from those policies and exit that insurance market via appropriate reinsurance.¹⁰⁴ This allows a certain amount of flexibility to insurers by allowing them to shift direction in their future business choices.¹⁰⁵

A few caveats are necessary here. By reinsuring the entire loss, the primary insurer generally has not freed itself from its direct responsibilities to its policyholders, despite even a 100% risk transfer to the reinsuring companies. In other words, though it may have successfully transferred the risks of loss, it did not transfer its servicing responsibilities to the reinsurer. Again, reinsurance is generally defined as a secondary indemnity agreement and the reinsurer does not usually assume a direct claims handling relationship with the policyholders of the reinsured.¹⁰⁶ Reinsuring agreements can, however, include “cut-out” provisions, which allow a direct action by the policyholders against the reinsurer; provisions like these change the reinsuring relationship.¹⁰⁷

¹⁰³ JERRY, *supra* note 9, § 140[a], at 1056-57 (“Just as reinsurance enables an insurer to take on new business, reinsurance can also be used to enable an insurer to leave a particular kind of business quickly. An insurer that wants to rid itself of a particular kind of coverage can solicit reinsurance for all of the insurance the carrier has written, which effectively takes the insurer out of the business and makes the reinsurer the insurer for all of the risks.”).

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, at § 40.01 (“In essence, reinsurance is insurance for insurance companies. It is a contractual arrangement under which an insurer secures coverage from a reinsurer for a potential loss to which it is exposed under insurance policies issued to original insureds. The risk indemnified against is the risk that the insurer will have to pay on the underlying insured risk. Because reinsurance is a contract of indemnity, absent specific cash-call provisions, the reinsurer is not required to pay under the contract until after the original insurer has paid a loss to its original insured.”).

¹⁰⁷ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 27 (noting the definition of the term ‘cut-through endorsement’ as “an endorsement to an

One benefit of the reinsurer's role instead of the primary insurer role is that the reinsurer is generally free from direct original policyholder action. For this reason, the standards of contract performance and the mutual obligations of the reinsured and reinsurer differ in type and structure from that of policyholder and insurer. Some of these relationships and the differences of obligations are described in Section IV of this Essay. Too much direct interaction by the reinsurer and the original policyholder will force the reinsurer to be treated simply as an insurer of the policyholder, obviating some of the benefits and performance obligations associated with the reinsuring agreement, usually to the reinsurer's detriment. Likewise, though there is nothing to prevent the kind of direct assumption of the primary insurer's role, such a situation really is better understood as a novation of the original primary insurance policies, rather than the type of reinsurance agreement for business agility that is the more common purpose of seeking reinsurance for indemnity purposes.

Another brief caveat is also useful here. Placing reinsurance for 100% of a certain type of underwriting business for the purpose of exiting the business is likewise different from another type of 100% reinsuring agreement that displays certain similar characteristics. In "fronting agreements", an insurer will enter into a policy with the understanding that another party, a reinsurer, will be responsible for the entire amount that it is required to pay under the policy.¹⁰⁸ One New York court described a fronting agreement or "fronting cessation" as an arrangement where an insurer issues a policy on a risk "with an understanding that another party will insure it".¹⁰⁹ The purpose of these "fronting agreements" is to allow a reinsurer not qualified or licensed to do business in the state, the

insurance policy or reinsurance contract which provides that, in the event of the insolvency of the insurance company, the amount of any loss which would have been recovered from the reinsurer by the insurance company (or its statutory receiver) will be paid instead directly to the policyholder, claimant, or other payee, as specified by the endorsement, by the reinsurer.").

¹⁰⁸ See *Reliance Ins. Co. v. Shriver, Inc.*, 224 F.3d 641, 643 (7th Cir. 2000) (describing a fronting agreement as a "well established and perfectly legal scheme" where policies are issued by state-licensed insurance companies and then immediately reinsured to 100 percent of face value).

¹⁰⁹ *Allendale Mut. Ins. Co. v. Excess Ins. Co.*, 970 F. Supp. 265, 267 n.2 (S.D.N.Y. 1997).

opportunity to profit from the sale of insurance transactions in that state.¹¹⁰ Generally, the licensed insurer will receive a fee for acting as the “front”.¹¹¹ Despite the slightly pejorative terms used in this arrangement, there is nothing illegal in a domestic insurer acting as a front for the unauthorized insurer. In fact, so long as all other regulatory goals are met, these relationships can allow for a significant increase in insurance capacity.¹¹²

D. LOSS STABILITY

Finally, and perhaps most importantly, reinsurance is a mechanism for insurers to stabilize their profits and expected losses.¹¹³ Insurance does and always has concerned risk.¹¹⁴ Using reinsurance, the primary insurer can set a limit on its exposure by facultative insurance for any given risk, use a surplus treaty to create a ceiling on aggregate loss or determine its percentage of risk retained through a pro-rata arrangement.¹¹⁵ In this way,

¹¹⁰ See *Union Sav. Am. Life Ins. Co. v. North Central Life Ins. Co.*, 813 F. Supp. 481, 484 (S. D. Miss. 1993).

¹¹¹ See *Venetsanos v. Zucker, Facher & Zucker*, 638 A.2d 1333, 1336 (N.J. Super. Ct. App. Div. 1994).

¹¹² NEW APPLEMAN INSURANCE LAW PRACTICE GUIDE, *supra* note 8, at § 40.04[5] (“A licensed reinsurer can front for an unauthorized reinsurer or a reinsurance syndicate, to permit the ceding insurer to take credit for the reinsurance without need for security.”).

¹¹³ JERRY, *supra* note 9, § 140[a], at 1057 (“A fourth purpose of reinsurance is to stabilize insurers’ profits and losses.”).

¹¹⁴ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 49 (noting the definition of the term ‘risk’ as “a term which defines uncertainty of loss, chance of loss, or the variance of actual from expected results as it relates to coverage provided under an insurance or reinsurance contract. Also the term is used to identify the object of insurance protection, e.g., a building, an automobile, a human life, or exposure to liability. In reinsurance, each ceding company customarily makes its own rules for defining a risk.”).

¹¹⁵ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 4 (“Insurers often seeks to reduce the wide swings in profits and loss margins inherent to the insurance business. These fluctuations result, in part, from the unique nature of insurance, which involves pricing a product whose actual cost will not be known

even cumulative losses can be restricted to designated limits.¹¹⁶ The insurer uses reinsurance as a form of stability control, enabling them to fulfill their obligations to policyholders in a continuous manner¹¹⁷ and potentially stabilize their profits.¹¹⁸

IV. REINSURANCE AS PRIVATE REGULATOR

As we have seen, reinsurance is a flexible and multifunctional arrangement. If the benefits of reinsurance to insurers were not so attractive, this multinational, trillion dollar industry would not be nearly such a popular choice of insurers. Yet, the potential for reinsurance to affect the business conduct of insurers has not been among insurance regulatory concerns. This is likely because reinsurance is considered to consist of agreements between sufficiently sophisticated parties so as to require little formal regulatory oversight of the relationship. That conclusion, however, precludes the understanding that through the medium of contracting for reinsurance, the insurer subjects itself to limitations – a kind of private legislation- similar to that of a consumer policyholder with its insurer. Just as with primary insurance, the existence of a reinsurance agreement limits the options of insurer action if they wish to benefit from the reinsuring agreement.

until sometime in the future. Through reinsurance, insurers can reduce these fluctuations in loss experience, and stabilize the company's overall operating results.”).

¹¹⁶ JERRY, *supra* note 9, § 140[a], at 1057 (“Through reinsurance, the maximum losses on policies can be kept to manageable levels, and cumulative losses over a period of time can be kept within a designated limit.”).

¹¹⁷ *Corcoran v. Universal Reins. Corp.*, 713 F. Supp. 77, 82 (S.D.N.Y. 1989) (“Insurance companies depend upon reinsurance contracts for financial stability and hence their ability to fulfill their obligations under their policies.”).

¹¹⁸ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 4 (“Insurers often seek to reduce the wide swings in profit and loss margins inherent to the insurance business. These fluctuations result, in part, from the unique nature of insurance, which involves pricing a product whose actual cost will not be known until sometime in the future. Through reinsurance, insurers can reduce these fluctuations in loss experience, and stabilize the company's overall results.”).

This is so because the reinsurance agreement is not one without conditions. Those conditions include everything from offering the reinsurer access to its underwriting philosophy¹¹⁹ and underwriting success rates, to providing defenses to reinsurance performance based on inadequate claims handling. Moreover, the sheer breadth of the advantages available to an insurer from reinsurance make it likely that a prudent insurer will keep in mind the requirements and interests of the reinsurance industry while setting its underwriting and claims handling mechanisms in place.¹²⁰ Just like a consumer policyholder will seek to keep his losses down to attract lower cost insurance, so will an insurer strive to make itself attractive to reinsurers.

Importantly, it must be recognized that reinsurance is generally not a one-off deal. Rather, reinsurance agreements are entered into for a specific time and are often then renegotiated.¹²¹ When a party is aware that its conduct under one agreement will affect the terms of its next agreement, it can only be assumed that the party will seek to mitigate activities which could have a future negative financial effect. If one can agree on nothing else as regards the insurance industry, the capacity for these companies to consider their long term financial interests should be somewhat obvious.

Another aspect of this discussion is not just that insurers seek to make themselves fiscally attractive risks to their reinsurers, an activity that

¹¹⁹ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 57 (noting the definition of underwriting capacity as “[t]he maximum amount of money an insurer or reinsurer is willing to risk in a single loss event on a single risk or in a given period. The limit of capacity for an insurer or reinsurer that may also be imposed by law or regulatory authority.”).

¹²⁰ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 3 (noting “[i]nsurers purchase reinsurance for essentially four reasons: (1) to limit liability on specific risks; (2) to stabilize loss experience; (3) to protect against catastrophes; and (4) to increase capacity. Depending on the ceding company’s goals, different types of reinsurance contracts are available to bring about the desired result.”).

¹²¹ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 13 (noting “reinsurance contracts must be shaped to the ceding insurer’s unique requirements. No two contracts are alike – all have marked variations in retention levels, coverages and exclusions. An insurance company’s needs for reinsurance depend on its book of business and financial and underwriting strategies. The reinsurance contract, and hence reinsurance premiums, must be individually tailored and determined by the parties.”).

any party seeking capital would undertake. Rather it is the identification that terms and standards common to the reinsurance relationship have the potential to affect insurance company action as regards their *primary* policyholder in areas that come within the bounds of current insurance regulatory interests. Specifically, insurer practices in underwriting and claims handling.

A. A BRIEF LOOK AT INSURANCE REGULATORY GOALS: THE IDEA OF “AEQUUM ET BONUM”.¹²²

Insurance regulation seeks to achieve a complex set of goals through the regulation of insurance. Regulation, as discussed earlier, frequently concerns itself with issues of insurer solvency.¹²³ This interest is not conceived of solely as an attempt to keep a lucrative industry functioning. Rather, insurer solvency regulation exists in large part to obviate the harm to insured policyholders who would be hurt as a result the insurer’s insolvency.¹²⁴ Unlike many other types of transactions, insurance does not lend itself to being the type of product that can be replaced if, just as a policyholder should come to need the insurer to perform, the policyholder were to learn that its company has defaulted as a result of insolvency. Put even more plainly, if insufficient reserves cause an insurer to default as a result of too many claims being made, in a catastrophe scenario for example, the negative externalities of that default are potentially extreme.¹²⁵

¹²² See BLACK’S LAW DICTIONARY 1383 (8th ed. 2004) (noting the term *secundum aequum et bonum* means “[a]ccording to what is just and good.”).

¹²³ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 13 (noting “reinsurance regulation focuses on solvency.”).

¹²⁴ See STARING, *supra* note 20, § 19, at 19-1 (noting “[r]einsurance has certain advantages which accrue to the insured public as well...reinsurance coverage represents an added shield protecting a policyholder against uncompensated loss. This advantage to the insureds is realized most obviously in the event of the primary insurer’s insolvency. “Thus, from the perspective of an insured or policyholder, the insolvency of the primary insurer may make any reinsurance the only or de facto source of at least partial compensation for losses incurred.”).

¹²⁵ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 4 (noting “[r]einsurance provides protection against catastrophic loss in much the same way

Solvency, however, is not the only goal of insurance regulation. Rather the mission of insurance regulators is also to assure consumers of fair treatment and protection from unfair trade practices.¹²⁶ Fairness can be seen to include appropriate access to insurance and the prevention of impermissible discriminatory practices and other notions of consumer protection. Taken as a whole, this amorphous “public policy” regulatory interest has perhaps been best characterized by some academics as the insurance regulatory principle of “Aequum et Bonum”.¹²⁷

Used to encompass a spectrum of “public good” regulatory objectives, the identification of this principle is a useful shorthand. These “public good” regulatory goals are translated into regulatory policy in a

it helps stabilize an insurer’s loss experience. Insurers use reinsurance to protect against catastrophes in two ways. First, reinsurance protects against catastrophic financial loss resulting from a single event, such as the total fire loss of a large manufacturing plant. Second, reinsurance also protects against the aggregation of many smaller claims resulting from a single event, such as an earthquake or major hurricane, that affects many policyholders simultaneously. While the insurer is able to cover losses individually, the aggregate may be more than the insurer wishes to retain.”).

¹²⁶ Insurance regulatory interests include the perennial issues of risk containment and default. However, risk of default is not the sole purview of insurance regulation. Included in regulatory efforts are issues of political interest, such as guaranteeing equitable access to insurance, and other redistributive and equitable normative policies. For example, the Connecticut Department of Insurance describes its mission as follows:

The mission of the Connecticut Insurance Department is to serve consumers in a professional and timely manner by providing assistance and information to the public and to policy makers, by regulating the insurance industry in a fair and efficient manner which promotes a competitive and financially sound insurance market for consumers, and by enforcing the insurance laws to ensure that consumers are treated fairly and are protected from unfair practices.

Connecticut Insurance Department: Our Mission Statement,
<http://www.ct.gov/cid/cwp/view.asp?q=254396>.

¹²⁷ See Howell E. Jackson & Edward L. Symons Jr., *Regulation of Financial Institutions* 452 (1998).

variety of ways and it has not escaped notice that “the objective of *aequum et bonum* is present in some degree to most systems of insurance law and regulation. It has many facets: It is equality. It is morality. It is fairness, equality, reasonableness. It may even be efficiency, economy, parsimony.”¹²⁸

Generally this principle is reflected in the tripartite goals that rates not be “excessive, inadequate or unfairly discriminatory”, the standard language in nearly every state’s regulatory legislation.¹²⁹ Likewise regulations prohibiting unfair trade practices in the handling of a claim are created in the interest of consumer protection and fairness.¹³⁰ This can be seen to reflect a somewhat disjointed effort to stay true to the “public interest” as best as it can be defined by regulators and courts while at the same time offering a private industry an opportunity for profit in an industry demanding regulated solvency. For this reason, underwriting practices, the assignment of rates to the sale of insurance, and its corollary – claims handling – are within the purview of insurance regulatory interest.¹³¹

In their regulatory efforts Insurance Commissioners have not apparently considered the potential effect reinsurance agreements could have on insurers performance of their obligations to their policyholders, nor does there appear to have been any systemic review of the public policy

¹²⁸ *Id.*

¹²⁹ This authorization for regulatory efforts in these identifiably somewhat conflicting and unclear goals is supported by the long standing identification of insurance as something other than a purely private contractual affair. As courts have long noted, “It is no longer open to question that the business of insurance is affected with a public interest . . . Neither the company nor a policyholder has the inviolate rights that characterize private contracts.” *Carpenter v. Pacific Mut. Life Ins. Co.*, 74 P.2d 761, 774 (Cal. 1937). Thus, “[t]he contract of the policyholder is subject to the reasonable exercise of the state’s police power.” *Id.* at 774-75.

¹³⁰ See National Association of Insurance Commissioners, *supra* note 13 (noting the NAIC works in conjunction with state insurance regulators in serving the public interest and facilitating “the fair and equitable treatment of insurance consumers.”).

¹³¹ See *id.* (noting fundamental insurance regulatory goals include protecting the public interest, promoting competitive markets, promoting the reliability, solvency, and financial solidity of insurance institutions, and supporting and improving state regulation of insurance.”).

concerns implicated by the availability of reinsurance for coverage of bad-faith extracontractual damages¹³² as a matter of consumer protection. In the next sections, we will identify how the core principle of reinsurance agreements- the reciprocal duty of good faith- when taken in concert with other common reinsurance doctrines and practices, have the capability of influencing insurer behavior on an industry wide scale. Likewise, we will review how the court's interpretation of these obligations have the potential to affect insurance claims handling decisions and practices. Finally, we will review a series of available reinsurance clauses that seem to be antithetical to consumer protection goals and reduction of coverage litigation.

B. GOOD FAITH AS A REGULATOR OF UNDERWRITING AND CLAIMS HANDLING PRACTICES

Reinsurance obligates the parties to act in good faith.¹³³ In fact, in can be said that this duty of good faith – enforced by the courts- is the core principle by which reinsurance operates in its myriad forms.¹³⁴

¹³² See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 29 (noting the definition of extra-contractual obligations as “monetary awards or settlements against an insurer for its alleged wrongful conduct to its insured. Such payments required of an insurer to its insured are extra-contractual in that they are not covered in the underlying contract.”).

¹³³ See PLITT, *supra* note 9, § 9:17, at 56-57 (noting “[d]uties of good faith and fair dealing run between the reinsurer and the reinsured much as they do between the initial insured and his or her insurer. This duty originates from the reinsurer’s need to rely upon and not duplicate the reinsured’s efforts in properly evaluating risks and handling claims, reducing costs for both parties to the reinsurance contract. Accordingly, this duty requires the reinsured to disclose to the reinsurer all material facts which may affect the subject risk.”).

¹³⁴ See STARING, *supra* note 20, § 12:1, at 1-2 (“The long and well established tradition that reinsurance transactions are a matter of ‘utmost good faith’ between the parties has had a predictable effect on the preparation of reinsurance contracts...The typical reinsurance contract is a relatively short, concise document, noticeably lacking in the legalisms so characteristic of other types of contracts. This underlying assumption of utmost good faith allows the companies to draft a document that assumes both parties are so knowledgeable on the subject matter to be dealt with and possess such a degree of sophistication as to preclude the necessity got long, expository declarations of intent and implementation.”).

Importantly, courts reviewing this doctrine have often interpreted it to require specific insurance company behavior as a condition precedent to requiring reinsurer performance of its indemnity obligation.¹³⁵ Hence, failure to act in good faith affords the reinsurer a defense to its reinsurance obligation.¹³⁶ Since reinsurance is frequently only triggered by extremely large dollar value claims, preventing the release of its reinsurer for a lack of good faith behavior will undoubtedly be of paramount concern to a prudent insurance company.

i. *The Duty of Good Faith in Underwriting*

One of the strangest aspects of reinsurance is the often overlooked question of how reinsurance could ever exist without becoming cost prohibitive. If one were to simply think about reinsurance in terms of risk assessment, there seems little way that the addition of multiple new players in the insuring process would not add and continue adding to the cost of insurance. After all, due diligence is an expensive proposition. How could all these different reinsurance institutions capably evaluate the true risks of all the policies which they agree to reinsure, particularly in the treaty context, without accruing costs as large as, if not larger than, the original insurer?¹³⁷ The answer is simply that in the reinsurance treaty context they simply do not engage in that kind of investigation, instead they rely on the underwriting skills of their reinsureds.¹³⁸ Investigation costs are limited to

¹³⁵ See e.g. *Liquidation of Union Indemn. Ins. Co. v. Am. Centennial Ins. Co.*, 674 N.E.2d 313, 319-20 (N.Y. 1996).

¹³⁶ See JERRY, *supra* note 9, § 142[c], at 1059 (“The primary insurer and reinsurer have a duty to deal with each other in good faith, and the reinsurer will have available to it the defense of misrepresentation, breach of warranty, fraud, or concealment in circumstances where the primary insurer’s acts or neglect give rise to the defense.”).

¹³⁷ See PLITT, *supra* note 9, § 9:17, at 56-57 (“Duties of good faith and fair dealing run between the reinsurer and the reinsured much as they do between the initial insured and his or her insurer. This duty originates from the reinsurer’s need to rely upon and not duplicate the reinsured’s efforts in properly evaluating risks and handling claims, reducing costs for both parties to the reinsurance contract.”).

delving into the potential reinsured's loss experiences, underwriting skills and claims handling competence.¹³⁹

How is action like that considered prudent? As we have seen to our great dismay in the sub-prime mortgage crisis, the consequences of opaque risk acquisition can be remarkably severe. In reinsurance, the reciprocal obligations of good faith obviates this problem in the reinsurance context.¹⁴⁰ In reinsurance, this duty often requires, "the most abundant good faith; absolute and perfect candor or openness and honesty; [including] the absence of any concealment or deception, however slight".¹⁴¹ Viewing utmost good faith as appropriately sufficient to govern trillions of dollars of transactions is interesting in and of itself, yet, as the

¹³⁸ See STARING, *supra* note 20, § 2:6, at 7 ("The reinsurer will always have at least a general, if not a particular, interest in the integrity of the reinsured's underwriting and claims practices.").

¹³⁹ *Id.*

¹⁴⁰ See PLITT, *supra* note 9, at 57-58 ("[The duty of good faith] requires the reinsured to disclose to the reinsurer all material facts which may affect the subject risk. The extension of this duty of good faith is the related concept that reinsurers are generally bound by the reinsured's good faith decision to pay a claim, commonly referred to as the 'follow the settlements' doctrine. The purpose for this rule is to prevent situations in which reinsurers, in attempt to deny coverage, use against the reinsured the same coverage arguments made by the reinsured against the original insured, essentially eroding the good faith relationship needed in the reinsurance context. The limiting factor, preventing the abuse of this doctrine, is the determination of whether the reinsured's payment was made in good faith.").

¹⁴¹ See JERRY, *supra* note 9, § 142[c], at 1060. (noting that good faith "is the position of reinsurers that their contracts are those of 'utmost good faith.' Utmost good faith contracts of any kind are so delicate in character and so susceptible of abuse that unusual precautions must be observed by both parties in their implementation. The business of reinsurance often involves considerable oral exchange of information between primary insurer and reinsurer, and the reliability of this information is very important. The resemblance of the customary practices to how business used to be conducted at the Lloyd's Coffee House of old is unmistakable. The strict law of warranty which applied to the old transactions at Lloyd's probably has something in common with the duty of 'utmost good faith' which applies in reinsurance. Both doctrines have the effect of ratcheting up the expectations contracting parties can reasonably possess with regard to the accuracy of information shared by the other party.").

Second Circuit has noted, it is the core relationship that allows for reinsuring to profitably occur. As they explained:

Historically, the reinsurance market has relied on a practice of the exercise of good faith to decrease monitoring costs and ex ante contracting costs. Reinsurance works only if the sums of reinsurance premiums are less than the original insurance premium. Otherwise, the ceding insurer will not reinsure. For the reinsurance premiums to be less reinsurers cannot duplicate the costly but necessary efforts of the primary insurer in evaluating risks and handling claims. . . . Reinsurers are protected, however, by a large area of common interest with ceding insurers and by the tradition of utmost good faith, particularly in the sharing of information.¹⁴²

In other words, in exchange for placing the reinsurance at a price less than the original premiums, the reinsurer is allowed to rely on the good faith of the reinsured.¹⁴³ In order for treaty reinsurance to function economically, the reinsurer cannot duplicate the underwriting functions engaged in by insurers at the time they placed the original coverage.¹⁴⁴

¹⁴² *Unigard Sec. Ins. Co., Inc. v. North River Ins. Co.*, 4 F.3d 1049, 1054 (2d Cir. 1993).

¹⁴³ See JERRY, *supra* note 9, § 142[c], at 1060. (“Not all insurance law doctrines are ratcheted up when it comes to reinsurance arrangements, however. As one court explained, ‘[r]einsurance contracts, unlike primary insurance contracts, are not contracts of adhesion. Rather, reinsurance involves two sophisticated business entities familiar with the business of reinsurance who bargain at arms-length for the terms in their contract.’ Thus, a rule like the notice-prejudice rule, which is designed to equalize the relationship between insured and primary insurer, may be deemed irrelevant to the reinsurance setting, and an insurer that fails to give timely notice to a reinsurer may find itself unable to defeat the reinsurer’s late notice defense on the ground that the reinsure failed to show prejudice.”).

¹⁴⁴ See ERIC M. HOLMES & L. ANTHONY SUTIN, *HOLMES’ APPLEMAN ON INSURANCE* § 102.4(a) (2d ed. 2000) [hereinafter *HOLMES’ APPLEMAN ON INSURANCE*] (noting “[u]nderwriting is largely retrospective, focusing on the

However, that does not mean the reinsurer does not take an interest in the underwriting activities of its reinsureds. As explained by the Reinsurance Association of America:

While treaty reinsurance does not require review of individual risks by the reinsurer, it demands careful review of the underwriting philosophy, practice and historical experience of the ceding insurer, including a thoughtful evaluation of the company's attitude toward claims management, engineering control, as well as the management's general background, expertise and planned objectives.¹⁴⁵

Keeping these criteria in mind, it is difficult to imagine insurance companies would not create and institutionalize underwriting practices that are most likely to attract reinsurers if they want to benefit from reinsurance.¹⁴⁶ Moreover, the reinsured company would want to ensure that it kept particularly good records of its underwriting efforts, as they are required by their good faith obligation to "disclose to the reinsurer all material facts which may affect the subject risk".¹⁴⁷

So great is the reinsurer recognition of their risk in relying on the underwriting decisions of their reinsured's that reinsurance contracts frequently include a clause which allows the reinsurer access to their reinsured's "books and claims and underwriting files",¹⁴⁸ if it finds such an

financial condition and expertise of the ceding insurer. A reinsurer would be well-advised, however, to undertake a careful review of the practices and standards of a prospective reinsured under a treaty. Many reinsurance treaties embody longstanding relationships between the parties and have been renewed many times over the decades.").

¹⁴⁵ See Reinsurance Association of America, *supra* note 11, at 7.

¹⁴⁶ See STARING, *supra* note 20, § 2:6, at 7. ("The reinsurer will always have at least a general, if not a particular, interest in the integrity of the reinsured's underwriting and claims practices.").

¹⁴⁷ See PLITT, *supra* note 9, § 9:17, at 57.

¹⁴⁸ See STARING, *supra* note 20, §15:8.

audit necessary. Known as “audit and inspection clauses”, these clauses require “the reinsured’s records relative to the contract sessions to be always open to the reinsurer at reasonable times.”¹⁴⁹ These clauses offer an opportunity for the reinsurer to review their reinsured’s underwriting and claims handling practices to assure itself that the reinsured company is acting in conformance with its expectations and that the claims made on it come within scope of its reinsurance contract.¹⁵⁰ By this method, reinsurer’s have the capacity to keep themselves abreast of their reinsured’s underwriting and claims handling practices in an ongoing manner, when such inquiry is reasonable. And, in the event of a dispute it allows them the opportunity for a direct audit.

ii. *The Capacity of Reinsurance to Stifle Underwriting Innovation*

The search for information implies the capacity for reaction. The interplay of the duty of good faith and audit clauses offer the reinsurer the opportunity to monitor their reinsured’s practices. Such monitoring has the capacity to influence the way in which reinsured’s create and apply their underwriting discretion. Particularly for smaller insurance companies, dependant on reinsurance to take on the larger risks, it would not be beneficial to adopt underwriting practices which stray too far from the industry’s accepted norm.¹⁵¹ Should such a company attempt it, undoubtedly the company would have to charge higher premiums in order

¹⁴⁹ *Id.* (noting that this right is not without limits and does not permit access to all the reinsured’s books generally, rather the audit is limited to the scope of the relationship between the parties).

¹⁵⁰ *Id.* (noting that audit and inspection clauses are found in both treaty and facultative agreements so that treaty reinsured must make available their relevant books and facultative reinsured’s must keep the reinsurer “advised at various levels of detail with respect to claims under the policy”).

¹⁵¹ *See* REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 5-6 (noting “reinsurers often provide insurers with a variety of other services. Some reinsurers provide guidance to insurers in underwriting, claims reserving and handling, investments, and even general management. These services are particularly important to smaller companies interested in entering new lines of insurance.”).

to entice reinsurers to take on their risks.¹⁵² Likewise, those companies which require greater amounts of reinsurance to comply with their reserve requirements could also be discouraged from adopting broader or unusual underwriting procedures.¹⁵³

The inclusion of the reinsurer's interest of "underwriting philosophy", "historical experience of the ceding insurer" and "attention to the attitude of claims management" suggest that to the extent the industry profits from and seeks reinsurance for its business interests, those interests will militate in favor of choices which may not be completely congruent with all aspects of the regulators objectives; particularly those objectives which come within the broad understating of *aequum et bonum*. It is not beyond the realm of possibility that access to insurance could be restricted for less profitable groups or only offered at a higher cost, implicating notions of fairness.

Though reinsurance monitoring may have the capacity to somewhat stifle or raise the cost of innovation, perhaps even to the point of raising issues of unfairness, there may well be some positive public good from the effect of reinsurance monitoring of underwriting practices. Reinsurers' interest in the underwriting and claim handling processes of its reinsureds might well suffice as a strong financial incentive towards maintaining professional and non-biased underwriting practices – a regulatory goal. The reinsurer's sole interest is its own financial one. To that end, the industry will seek out and reward those insurers who most accurately measure and rate risks. Though the reinsurance industry may not have an active incentive to broaden access to insurance for public policy reasons, it also has no active disincentive to restrict the sale of properly underwritten policies. As a whole, reinsurers profit from having insurance policies available to reinsure. Given the capacity for reinsurance to assist small insurers to compete on an asset basis with larger companies,

¹⁵² New insurance lines are often covered facultatively until a sufficient loss history is developed to attract treaty reinsurance. See Hoffman, *supra* note 3, at 771. ("Demand for facultative reinsurance also exists for new insurance lines, specialty lines, or insurance products that are developed to cover traditionally uninsured risks. Such risks and exposures, if accepted by a reinsurer, are likely to be accepted only on a facultative basis because they transcend existing actuarial and ratemaking techniques.").

¹⁵³ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 48 (noting the term 'reserve' means "[a]n amount which is established to provide for payment of a future obligation.").

reinsurance's availability can act to support companies writing policies for previously underserved policyholders. In any event, reinsurers' interest in the underwriting procedures of those they reinsure undoubtedly serves the pseudo-regulatory function of encouraging actuarially sound underwriting practices by rewarding those companies with greater access to reinsurance. For this reason alone, reinsurance can be perceived as effecting industry practice beyond questions of solvency.

iii. *Reinsurer Monitoring of Underwriting History and the Potential*

For Market Response, the risk of reinsurance rate consequences does appear to effect insurance industry practice. A look to the facultative reinsurance market suggests that insurers are very concerned in maintaining attractive loss histories and are sensitive to reinsurance costs when making underwriting decisions. Remember, facultative reinsurance is used to mitigate the effect of the phenomena of the unusual risk costing more than the easily forecastable risk and is usually placed when the risk would not be accepted under a treaty.¹⁵⁴ Again, it is through facultative reinsurance that an insurer could acquire reinsurance for a specific risk, a specific policy or a specific group of policies.¹⁵⁵ It is for this reason that facultative

¹⁵⁴ See Hoffman, *supra* note 3, at 770-771 ("By definition facultative placements involve risks that fall outside the general parameters of a treaty reinsurance program. Facultative reinsurance is purchased by primary insurance companies, captives, or reinsurers to cover assumed business that, for one reason or another, will not be ceded to a treaty.").

¹⁵⁵ See STARING, *supra* note 20, § 1:4 at 7-8. ("Facultative reinsurance of a single risk, which was undoubtedly the original type, continued dominant until the last half of the Nineteenth Century. A treaty, which is a long term contract covering more than one risk, is known to have existed as early as 1821. Treaties became common around the beginning of the Twentieth Century and one form, the excess of loss treaty, is said to have become widespread as a result of the San Francisco earthquake and fire of 1906."). See also JERRY, *supra* note 9, § 140[b], at 1054 ("Facultative reinsurance involves the primary insurer entering into an agreement for the reinsurance of a particular risk. The reinsurance can be written on a pro rata or an excess basis; the root word 'faculty' denotes that the reinsurer has a choice of accepting or rejecting any risk proposed and of demanding whatever premium it thinks appropriate.").

reinsurance “usually covers catastrophic or unusual risks”.¹⁵⁶ Facultative reinsurance, however, will likely be more expensive per risk than broader treaty reinsurance because with facultative reinsurance the reinsurer often employs “substantial personnel and technical resources” to underwrite those risks.¹⁵⁷ Treaty reinsurance avoids this kind of cost.

Yet, it is common practice to combine treaty and facultative reinsurance to protect an insurer’s loss history with its treaty reinsurer. Companies often use facultative insurance to protect loss histories even though reinsurance coverage for the facultative risk already existed under treaty reinsurance agreements. The insurer’s strategic decision to enter the additional facultative agreement as a hedge against unexpected losses on a risk is done with an eye out to protect against losses which would otherwise have the capacity to trigger a renegotiation of the insurer’s entire treaty or cause future treaties to be reinsured at a higher cost.

As an example, the Reinsurance Association of America¹⁵⁸ describes a situation where in order to accommodate a policyholder, an insurer may agree to provide commercial automobile insurance coverage – a higher risk activity. The RAA argues that additional facultative reinsurance¹⁵⁹ would be appropriate in this situation even if the treaty reinsurance¹⁶⁰ the insurer had already placed did not exclude commercial

¹⁵⁶ See Reinsurance Association of America, *supra* note 11, at 7.

¹⁵⁷ *Id.* at 8.

¹⁵⁸ See REINSURANCE ASSOCIATION OF AMERICA, *Who We Are*, <http://reinsurance.org/i4a/pages/index.cfm?pageid=3615>. (The RAA describes themselves as “...a national trade association, headquartered in Washington, D.C., that is committed to an activist agenda to represent the interests of the property and casualty reinsurance industry in Congress, state legislatures, and international forums.”).

¹⁵⁹ See HOLMES’ APPLEMAN ON INSURANCE, *supra* note 152, at §102.4(b) (noting “[a] facultative reinsurance contract is written to cover a specifically identified risk. Both the ceding insurer and the reinsurer have the option (or ‘faculty,’ from the Latin for ability) to affect reinsurance on a risk-by-risk basis. Neither is obligated to cede or assume any given risk.”).

¹⁶⁰ *Id.* (noting “reinsurance treaties are blanket agreements negotiated between an insured and a reinsurer under which reinsurance is automatically provided for all policies issued by the insured that meet the criteria of the treaty. Treaty reinsurance is sometimes (but rarely) called automatic reinsurance. When a treaty

automobile coverage to “protect its losses under applicable treaty agreements”. As the RAA points out, the facultative “rider” need not even be purchased from the treaty reinsurers, allowing those potential commercial automobile losses to be handled under a completely separate relationship. This suggests the overall cost of ongoing higher treaty premiums is sufficiently grave to encourage the additional cost of “double reinsuring” certain risks, even at the relatively higher specific cost of the facultative agreement.

In any event, this common choice to pair facultative with treaty reinsurance to protect loss histories¹⁶¹ supports the conclusion that reinsurance monitoring of loss histories does effect reinsurance choices. This monitoring of underwriting practices¹⁶² has the capacity to effect underwriting decisions holistically and possibly industry-wide as insurers choose to implement practices that conform to the reinsurance market’s interests and prevent them from making underwriting risks which may negatively affect their reinsurance opportunities. To an extent, this natural interplay of loss history with reinsurance costs can create a self-regulating and self-limiting tendency among certain insurers to produce loss histories lower than similarly situated insurers.

Whether this activity is congruent with all articulated insurance regulatory interests is open to question, but there certainly exists the potential for segmentation of the market and increased costs for some policyholders. The simplest way for insurers to decrease loss histories is to restrict their business to lower risk policyholders or limit their dollar exposure to those risks. A “cherry picked” book of business, for example

is in force, the ceding insurer is obligated to cede and the reinsurer is obligated to accept all of the risks within the scope of the treaty.”).

¹⁶¹ See *id.* (noting “a reinsured can structure an elaborate program of reinsurance using a combination of treaties and facultative contracts, using one or multiple reinsurers.”).

¹⁶² Not only are underwriting practices monitored on a general basis, but in conformity with the reinsurer’s need to rely on their reinsured’s underwriting expertise, the duty of good faith requires the reinsured to disclose to the reinsurer all material facts which may affect the insured risk. See OSTRAGER & NEWMAN, *supra* note 10, at § 16:03[a], at 1036-37 (“It is a basic obligation of a reinsured to disclose to potential reinsurers all material facts regarding the original risk of loss, and failure to do so renders a reinsurance agreement voidable or rescindable.”).

could attract more reinsurance interest; as a result, the cherry-picking insurer can charge lower premiums to gain an even bigger bowl of cherries.

To the extent that this segmentation would not have occurred but for the reinsurance interests, reinsurance can be seen as having an effect on underwriting. There would still be an interest in insuring and reinsuring lemons, of course, so long as they can and will pay higher premiums which could be shared with the reinsurer, but the potential for reinsurance pricing to encourage cherry-picking can be somewhat troubling. The competitive advantage an insurer can obtain through reduced reinsurance premiums may militate against the traditional benefits afforded by the law of large numbers. The insurer could determine their best option for profit lay in the reinsurance cost saving produced by the lower risks.

An insurer with a sufficiently broad market share and multi-line business, of course, could get what would amount to a “bulk discount” for placing most of its reinsurance business with one company. But, if smaller insurers took the “cherry” approach and were rewarded with sufficiently lower premiums to compete against even the “bulk” advantage, the move towards segmentation would start when the big insurer slowly (or even quickly) began to loose enough of its cherries to affect its loss history in a way significant enough to offset its “bulk” appeal to its reinsurers. Remember, the reinsurance market is extremely broad, with at least 50% of domestic insurers reinsured by foreign companies.¹⁶³ There is likely always some reinsurer around with a taste for cherries.

Importantly, reinsurance’s effect on cherry-picked risk premiums does not always result in the company actually restricting their business to those “better” risks alone. There is no reason why reinsurance treaties must be structured so as to take the entire book of business for a certain type of risk, though they often are structured that way.¹⁶⁴ An insurer could reinsure with one company for their “better” risks at the lower prices, seek a competitive advantage on the market, and move the worse risks into a

¹⁶³ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 1 (“Reinsurance can be purchased from three distinct sources: reinsurance companies located in the United States, reinsurance departments of U.S. primary insurance companies, and alien reinsurers that are located outside the U.S. and not licensed here. The ceding insurer may purchase reinsurance directly from a reinsurer or through a broker or reinsurance intermediary.”).

¹⁶⁴ See HOLMES’ APPLEMAN ON INSURANCE, *supra* note 152, at § 102.4A, at 32 (noting “[a] treaty may be written to cover some or all of an insurer’s line of business”).

different book charged higher premiums; premiums sufficient to entice a different reinsurer. A different insurer could acquire better overall pricing by averaging the two pools, but it could face difficulty getting those cherries away from the segmented insurer, moving the whole market towards segmentation.

There is also the possibility that certain types of policyholders – likely corporate ones- which could be sufficiently attractive to an insurer so as to make the relative reinsurance benefits irrelevant. If, for example, the worse risks in one line were restricted to those who proved more profitable for the company on some other business basis, like companies interested in multi-line policies or companies which in some sense represent loss leaders, the higher reinsurance premiums could be offset for even those “worse” risks. This offset provides the book of business with a competitive advantage. Yet, even that potential benefit would have to be consistently reevaluated in relation to current market rates and costs of reinsurance. If the advantage of getting the big book of business did not offset the higher reinsurance rates, it would no longer be profitable, forcing the insurer to raise its rates across the board. And, just as with the possible loss of cherries scenarios described above, if another insurance company could convince the multi-line user it was better served by spinning off the insurance of its cherry risks for a significantly lower premium; such competition could again support a move toward segmentation.

Unfortunately, in all these scenarios, there exists the risk of identification of a certain class of generally unattractive risks with fewer insuring options other than higher premiums. Hence, restrictive underwriting in the search for lower reinsurance costs can be seen as having the capacity to self-support segmentation through beneficial reinsurance rates. To the extent that reinsurance was the “but for” cause of this segmentation and increased costs for certain classes of risks, reinsurance is acting as a regulator of insurance rates and should certainly come within governmental regulatory review.

It would be extremely interesting to identify empirically whether certain state actions, such as prohibiting coverage refusals to certain classes of policyholders in their state results in an initial spike in the cost of reinsurance for the reinsureds who must extend their underwriting in conformity with those new mandates. Likewise, it would be very interesting to determine how long, if at all, such a spike continued to exist and whether a new underwriting requirement became sufficiently common that the effect disappeared.

iv. *Reinsurance Clauses, Doctrines and Their Effect on Claims Handling*

As with underwriting¹⁶⁵, reinsurance has the capacity to influence the activities of reinsureds, or those seeking to become reinsureds, attitudes and actions in the claims handling process. Because of the manner in which the reinsured's good faith obligation¹⁶⁶ has been interpreted by courts so as to offer the reinsurer a defense to its indemnity obligations, the proper handling of a potentially reinsurable claim is likely paramount to any prudent reinsured. Even though, as described below, the claims handling would have to be so poor to constitute some form of "negligence" to succeed as a defense, the risk of lost reinsurance funds is no small matter. Further, given the fact that claims handling processes and "philosophy" are reviewed as part of reinsurers decision to reinsure (just as with underwriting), adoption of formalized claims handling processes which would assure compliance with the reinsurance "non-negligent" claims handling standard is not unlikely. As we will see, the actions which a court might construe as "negligent" handling and investigation of a claim are neither necessarily intuitive nor without cost.

v. *Duty of Good Faith in Claims Handling and Court Interpretation*

In order to understand how the courts became arbiters of insurance claims handling sufficiency requires some explanation of a few new reinsurance doctrines and clauses – particularly the loss settlements or follow the fortunes doctrine.¹⁶⁷ Again, a key point to remember is that the

¹⁶⁵ See REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 57 (noting the term 'underwriting capacity' means "[t]he maximum amount of money an insurer or reinsurer is willing to risk in a single loss event on a single risk or in a given period. The limit of capacity for an insurer or reinsurer that may also be imposed by law or regulatory authority.").

¹⁶⁶ See *Commercial Union Ins. Co. v. Seven Provinces Ins. Co., Ltd.*, 9 F. Supp. 2d 49, 51-52 (D. Mass. 1998), *aff'd*, 217 F.3d 33, 40-41 (1st Cir. 2000); *Compagnie De Reassurance D'Ile de Fr., et al., v. New England Reins. Corp., et al.*, 57 F.3d 56, 88 (1st Cir. 1995), *cert denied*, 516 U.S. 1009 (1995).

¹⁶⁷ See William C. Hoffman, *Common Law of Reinsurance Loss Settlement Clauses: A Comparative Analysis of the Judicial Rule Enforcing the Reinsurer's*

duty of good faith is mutual and has been interpreted to create a powerful judicially-supported standard of care when examining the insurer's performance of its claims handling function.¹⁶⁸

Most reinsurance agreements requires the reinsurer to "follow the fortunes" or "follow the settlements" of its reinsureds. These obligations are somewhat intuitively understandably necessary so as to allow the proper functioning of reinsurance.¹⁶⁹ In short, the "follow the fortunes" doctrine¹⁷⁰ obligates a reinsurer to follow the underwriting fortunes of its

Contractual Obligation to Indemnify the Reinsured for Settlements, 28 TORT & INS. L. J. 659, 659-60 (1992) (offering an expansive analysis of the reinsurance loss settlement clause and the application of the duty of utmost good faith).

¹⁶⁸ See PLITT, *supra* note 9, at § 9:17 ("Duties of good faith and fair dealing run between the reinsurer and the reinsured much as they do between the initial insured and his or her insurer.").

¹⁶⁹ These doctrines are often conjoined in court decisions leading to certain amount of confusion in their analysis. See e.g., *Litho Color, Inc. v. Pac Employers Ins. Co., v. Home Ins. Co.*, 991 P.2d 638, 647 (Wash. Ct. App. 1999). This problem has been noted by both courts and commentators. See *Aetna Cas. & Sur. Co. v. Home Ins. Co.*, 882 F. Supp. 1328, 1346 n.9 (S.D.N.Y. 1995) (noting that "[t]he term 'follow the fortunes' has been used imprecisely to describe the reinsurer's duty to follow the claims adjustment decisions of the ceding company, thereby giving rise to some ambiguity as to its meaning. 'Follow the fortunes' more accurately describes the obligation to follow the reinsured's underwriting fortunes, whereas 'follow the settlements' refers to the duty to follow the actions of the cedent in adjusting and settling claims.").

¹⁷⁰ There is considerable debate as to whether there truly exists a "follow-the-fortunes" or "follow the settlements" doctrine in the absence of a "follow-the-fortunes" clause. Some treatises and courts identify a "doctrine". See PLITT, *supra* note 9, at § 9:17 ("reinsurers are generally bound by the reinsured's good faith decision to pay a claim, commonly referred to as the 'follow the settlements' doctrine") (discussing *ReliaStar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874, 878 (8th Cir. 2002) (the follow the fortunes "doctrine posits that if the cedent has acted in good faith in handling the claims presented to it and in providing coverage of the claims, the reinsurer may not second guess the coverage decisions of the cedent"). Other commentators are explicit that in the absence of a general loss settlement or other "follow-the-fortunes clause" the nature of reinsurance as an indemnity contract prohibits an implied-in-law obligation to reinsure a loss settlement unless the reinsured can prove actual—as opposed to a good faith belief of—liability. See Hoffman, *supra* note 174, at 679. The courts are aware of the split authority on the

reinsured and pay its share of a loss sustained by its reinsured,¹⁷¹ according to the terms of the reinsurance contract.¹⁷² This clause obligates a reinsurer to indemnify its reinsured for its good faith payment of all claims that arguably fall within the scope of the agreement – no “second guessing” allowed.¹⁷³ Likewise, a “follow the settlements” clause requires

matter. For example, in *Aetna Cas. & Sur. Co. v. Home Ins. Co.*, 882 F. Supp. 1328, 1349 (S.D.N.Y. 1995), the court, when finding in favor of the reinsured Aetna, stated:

Under Aetna's theory, it is the settled custom and practice in the reinsurance industry that reinsurers follow settlements entered into between a ceding company and its insured, as long as the settlements are made in good faith after a reasonable investigation and do not involve ex gratia payments. Essentially, Aetna maintains that a reinsurer's undertaking to follow the ceding company's settlements is implicit in any contract of reinsurance, and enforceable even in the absence of an explicit loss settlements clause. Home responds that in the absence of a loss settlements clause, a reinsurer is not bound by a ceding company's settlement of a coverage dispute without the consent of the reinsurer. *The court agrees with Aetna* (emphasis added).

The weight of authority appears to favor Aetna's position, although the authorities admittedly do not speak with one voice. For example, Gerathewohl opines that the “fundamental follow-the-fortunes principle” generally applies irrespective of whether it is expressed in the contract of reinsurance, i.e., in a loss settlement clause.

¹⁷¹ A reinsurer is not, however, required to pay losses “squarely outside” the scope of the ceding insurers coverage. See OSTRAGER & NEWMAN, *supra* note 10 at § 16.01[a], at 1013.

¹⁷² See *Commercial Union Ins. Co. v. Swiss Reins. Am. Corp.*, 413 F.3d 12, 1231 (1st Cir. 2005). The reinsurer cannot, however, be found liable for an amount in excess of the reinsurance limit of liability stated in the agreement. See *Unigard Sec. Ins. Co., Inc. v. N. River Ins. Co.*, 4 F.3d 1049, 1070-71 (2d Cir. 1993). This includes the reinsurer's liability for “expenses” as well as for the amount of the actual loss. See *Excess Ins. Co. v. Factory Mut. Ins. Co.*, 882 N.E.2d 768, 774-75 (N.Y. 2004) (finding that a reinsurers obligation for expenses incurred while handling a loss is capped by the limit of liability in a facultative agreement regardless of the presence of a “follow the fortunes” clause).

¹⁷³ See *N. River Ins. Co. v. Cigna Reins. Co.*, 52 F.3d 1194 (3d Cir. 1995) (“‘Follow the fortunes’ clauses prevent reinsurers from second guessing good-faith

indemnification of the reinsured for good faith settlement decisions.¹⁷⁴ Such broad grants of power by the reinsurer to the discretion of its reinsured is seen by the courts to require the insurer to comport with a standard of care appropriate to that level of reliance and in accordance with its good faith obligation. In its application, a reinsurer will only be bound by a reinsured's claims decision if the reinsured's decision was made in conformance with judicially created criteria for identifying insurer good faith.¹⁷⁵ Specifically, the claims decision must have been made after a "reasonable, businesslike investigation" into the propriety of the claim

settlements and obtaining de novo review of judgments of the reinsured's liability to its insured."). This standard, however, is not always completely clear in its application. See JERRY, *supra* note 9, at § 142[e], at 1061-62 ("The usual role of the reinsurer is to 'follow the fortunes' of the primary insurer as if the reinsurer were a party to the original insurance. Some courts insist that the reinsurance agreement have appropriate language placing this obligation on the reinsurer, while others presume that the reinsurer's obligations follow the form (although in most certificates 'follow the form' language will be found). As the phrase suggests, the idea is that the reinsurer is to accept whatever settlements the primary insurer makes and participate and pay according to the reinsurance agreement the appropriate share of whatever judgments are entered that trigger the primary insurer's liability. Difficulties can arise in determining exactly what 'fortunes' the reinsurer agreed to 'follow,' in that the reinsurer's obligation to participate in whatever payments the primary insurer makes is not unlimited.").

¹⁷⁴ In general, "[w]hen the reinsurance agreement contains a 'follow the settlements' provision, the reinsurer will be bound by the settlement or compromise agreed by the cedent unless it can meet its burden of proving either that settlement was dishonestly arrived at, or that the reassured has failed to take all proper and business-like steps to have the amount of loss fairly and carefully ascertained." OSTRAGER & NEWMAN, *supra* note 10, at § 16.01[b], at 1020. Unsurprisingly, there is some muddling of terms as regards the use of the word "settlement" in various clause formulae. See e.g. Mentor Ins. Co. (UK), Ltd., v. Norges Brannkasse, et al., 996 F.2d 506, 508, 516-17 (2d Cir. 1993) (construing a reinsurance policy which provided that it was "subject to all terms, clauses, conditions and settlements as original to require reinsurance "payment where cedent's good faith payment is at least arguably within the scope of the insurance coverage that was reinsured" using a "follow-the-fortunes" analysis.).

¹⁷⁵ See Hoffman, *supra* note 174, at 692-93 (noting "[d]ishonesty, including fraud, bad faith, and collusion, is a universally recognized defense to a loss settlement clause").

prior to granting it,¹⁷⁶ and where there was a “reasonable basis” to conclude the underlying claim was covered by the reinsured’s policy as a matter of law.¹⁷⁷

Since the obligation of good faith is mutual, the courts allow that certain circumstances, indicative of a lack of good faith, are sufficient for the reinsurer to be released from its obligation to reinsure. In other words, the court seeks a way to make sure the reinsurer is not taken advantage of by its reinsured. Particularly in the investigation and handling of the claim, in the absence of a reasonable standard, the reinsured could foreseeably choose not to investigate the claim properly to the financial detriment of its reinsurer. For this reason, the courts require the positive duty of reasonable and businesslike investigation of the claim by the cedent company. In theory, this likely only further strengthens the already extant interest of the reinsured company to be sure it is actually liable for coverage prior to payment – another instance where reinsurance supports a public interest by incentivizing prudence. In practice however, the availability of a defense on these grounds may lead to a reinsured cedent being overcautious in its claims review and handling at considerable expense.

vi. *The Case of Suter v. General Accident Ins. Co.*

One “follow the settlements” case is particularly illuminating of the capacity of “poor” claims handling to release the reinsurer from its indemnity obligation. In *Suter v. General Accident Ins. Co.*,¹⁷⁸ the court focused on claims handling improprieties in its decision to release the

¹⁷⁶ See Nat’l Am. Ins. Co. of Cal. v. Certain Underwriters at Lloyd’s London, 93 F.3d 529, 535 (9th Cir. 1996).

¹⁷⁷ See Hartford Accident & Indem. v. Colum. Cas. Co., 98 F. Supp. 2d, 251, 258 (D. Conn. 2000).

¹⁷⁸ *Suter v. Gen. Accident Ins. Co. of Am.*, 2006 U.S. Dist. Lexis 48209 (D.N.J. July 14, 2006), *vacated by*, *Goldman v. Gen. Accident Ins. Co. of Am.*, 2007 U.S. Dist. LEXIS 70406. Though this decision was vacated as a result of agreement by the parties prior to hearing by the Third Circuit, for purposes of a recent court’s analysis of the requirement of reasonable “businesslike” claim handling and investigation it is helpful. Instances where a court determines that the claims investigation was insufficient are rare, making this case of particular value for its findings of fact and reasoning.

reinsurer of its obligation arising from the reinsured's settlement.¹⁷⁹ The underling case and settlements involved product liability tort claims asserted against Pfizer, as the manufacturer of allegedly defective heart-valves, by patients who had received the potentially defective valves.¹⁸⁰ The manufacturer was the original insured which settled claims with the consent of Integrity Insurance Company, the original excess insurer which sought indemnity from General Accident Insurance Company of America, its reinsurer.¹⁸¹

Interestingly, the "claims handling" improprieties identified in this decision were all actually related to the reinsured excess insurer's legal acumen and choices made in evaluating and settling the claim.¹⁸² They primarily were issues involving the proper acquisition of independent coverage counsel and expert medical advice.¹⁸³ The court determined that failure to seek certain types of legal counsel and take certain investigatory steps, given the complexity of the case, constituted "gross negligence".¹⁸⁴

¹⁷⁹ See *id.*, at *77–85 (reviewing the actions of Mr. Reive, the Senior Claims Examiner for Integrity Insurance Company, excess insurance company whose reinsurance agreement with General Accident Insurance Company was the subject of the case).

¹⁸⁰ *Id.* at *13-34.

¹⁸¹ *Id.* at *8-13 (Pfizer had a classic array of multi-tiered insurance policies in place, with the company self-insuring for the first \$10 million of liability, followed by two primary policies issued by INA, the Insurance Company of North America, above which it had umbrella issued by Transit Casualty Company, along with excess policies issued by Integrity, the reinsured in this case. *Id.* The Integrity Policies "followed the form" of the Transit umbrella policies, making the policy language of the Transit policies the subject of interpretation to determine the scope of Integrity's liability. *Id.* at *10).

¹⁸² *Id.* at *34-66

¹⁸³ *Id.* at *81-85. ("for a case of this legal and medical complexity industry standards required Integrity to first obtain expert medical advice as to when bodily injury actually occurred and to retain its own coverage counsel for an opinion as to the appropriate trigger of coverage. The failure to do so . . . breached Integrity's duty to General Accident to make a reasonable, businesslike determination as to whether the Shiley Heart valve claims should have been allowed.").

The court cited the insurer's reliance on another insurer's counsel for its appraisal of potential liability as inappropriate.¹⁸⁵ Likewise, it cited failure of the insurer to hire its own medical expert (again it had relied on another insurer's expert) to advise on the heart-valves potential for bodily injury and a failure of the insurer to keep up to date on the laws of trigger of coverage as determinative factors.¹⁸⁶ Relying on these claims settlement investigation failures, the court further determined that the insurer had failed "breached its duty to General accident [the reinsurer] to make a reasonable, businesslike determination as to whether the [heart valve] claims should have been allowed."¹⁸⁷ The court also found the Pfizer claims beyond the scope of Integrity's policies and Integrity's settlement of the Pfizer claims to have been so grossly negligent so as to constitute bad-faith.¹⁸⁸ As such, the reinsurer was freed from its presumptively applicable duty to follow the insurer's settlement.¹⁸⁹

To those familiar with the tort litigation process, this demonstrates a privately assumed obligation's effect on the legal process and litigation costs. By focusing on the insurer's choice not to hire independent counsel or rely on other medical experts as grounds for release from reinsurance obligations, even in a case like *Suter* where such reliance was self-

¹⁸⁴ *Suter v. Gen. Accident Ins. Co. of Am.*, 2006 U.S. Dist. Lexis 48209, at *84 (D.N.J. July 14, 2006). The court's analysis of the "follow the settlements doctrine" requirement that the reinsured's duty to make a reasonable, businesslike investigation noted:

What is a reasonable, businesslike investigation of course must depend on the facts of each case. The factual findings support the conclusion that Mr. Reive's investigation was anything but reasonable and businesslike. Mr. Reive's investigation of the Pfizer claim was superficial, relying as it did on Pfizer's position and opinions of Transit's counsel, which were even at times inaccurate. The defendant has demonstrated that Mr. Reive did not make the kind of reasonable and businesslike investigation that the circumstances required. *Id.*

¹⁸⁵ *Id.* at *84-5.

¹⁸⁶ *Id.* at *81-85.

¹⁸⁷ *Id.* at *85.

¹⁸⁸ *Id.* at *85-86.

¹⁸⁹ *Id.*

evidently imprudent, the court explicitly allows the reinsurance contract obligation of reasonable investigation to affect the insurer's business judgment to save the cost of its own counsel or experts.¹⁹⁰ In effect, this type of decision will require the use of coverage counsel by each insurer implicated on a sufficiently "complex" claim that may implicate its reinsurance. It also has the potential to institutionalize the added cost of duplicative legal analysis and investigation of claims where reinsurance is implicated.¹⁹¹

To be sure, the *Suter* case, involved a significantly complex area of bodily injury law where the opinions of qualified legal and medical experts would likely have been sensible. Likewise, the Integrity claims handler probably should have kept abreast of legal changes implicating its obligations, given that directly relevant decisions had been made. However, there is no evidence that Integrity's claims handler had been acting collusively with any party, was attempting to perpetrate a fraud, or was not *subjectively* acting in good faith. The importance of the decision is in its recognition that the standard of competent and businesslike investigation will be one of industry standards, as discerned by the courts. It identifies how a generally common business practice can transform into a legal obligation. Though the court was not incorrect in identifying that the claims handlers ignorance may have been tantamount to malpractice in this instance, the decision has the capacity to effect business practices beyond the narrow fact situation of the ruling.

Though the application of the determined standard of care will always be fact specific to the situation reviewed for reasonableness, the capacity for a standard practice of requiring independent legal experts in "complex" cases could easily trickle down to "moderate" cases and then, perhaps, to "easy" coverage decisions. Even in cases where there would probably be little disagreement as to the likely value of the claims or medical evidence of causation, how could an insurer not be expected to cover its risk with duplicative legal opinions when the claim implicates its

¹⁹⁰ *Suter v. Gen. Accident Ins. Co. of Am.*, 2006 U.S. Dist. Lexis 48209, at *85-6 (D.N.J. July 14, 2006).

¹⁹¹ Good faith is a prerequisite for application of a reinsurer's indemnity obligations. *See ReliaStar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874, 878 (8th Cir. 2002) (finding that "doctrine posits that if the cedent has acted in good faith in handling the claims presented to it and in providing coverage of the claims 'the reinsurer may not second guess the coverage decisions of the cedent'").

reinsurance? Regardless where the line is eventually drawn as a matter of industry practice, one way or another, the litigation costs will eventually be internalized by the obligated insurers and passed to policyholders in the form of higher premiums.

Moreover, as the decision in *Suter* stems from the universally applicable good faith obligation of the insurer to reasonably investigate as a predicate to the reinsurer's performance under the reinsuring agreement, this duplicative effort could become simple industry practice for most claims in an overabundance of caution.¹⁹² Even if there is no reinsurer obligated on the particular claim, as discussed above, reinsurers investigate and monitor claims handling philosophy. It is possible that an insurer thinking about their future interest in reinsurance will take steps to ensure their claims handling demonstrates their history of operating in a non-grossly negligent manner and, if that requires a showing of the consistent use of its own independent medical experts and coverage counsel, such would likely be undertaken.

One caveat: it is of course possible that this added duplicative cost could be so cost prohibitive the insurer would prefer to simply avoid reinsurers and internalize the litigation savings. As described above, the benefits of reinsurance, particularly the ability to stabilize profits and leverage reserves makes such a choice unlikely.¹⁹³ For various reasons, an insurer remains aware of the chance it will in future need reinsurance. If anything, knowingly producing largely duplicative legal work would simply lead insurers to pressure their attorneys to reduce the cost of redundant legal services, if it cannot reduce the need to complete the work in the first place. Perhaps this accounts for some of the insurance industry's interest in creating legal services compensation structures which offer opportunities for "bulk rate" services and long-term billing agreements.

¹⁹² *Suter v. General Accident Ins. Co.*, 424 F. Supp 2d 781, 784, 788, 792 (D.N.J. 2006).

¹⁹³ REINSURANCE ASSOCIATION OF AMERICA, *supra* note 11, at 4 (noting "[i]nsurers often seek to reduce the wide swings in profit and loss margins inherent to the insurance business. These fluctuations result, in part, from the unique nature of insurance, which involves pricing a product whose actual cost will not be known until sometime in the future. Through reinsurance, insurers can reduce these fluctuations in loss experience, and stabilize the company's overall operating results.").

C. CONSUMER PROTECTION: DECLARATORY JUDGMENTS, BAD FAITH AND REINSURANCE COVERAGE

Since reinsurance is considered a business to business transaction, it is subject to significantly less regulatory oversight beyond issues of solvency. As described above, however, reinsurance's ability to indirectly affect the policyholder through inculcating and rewarding reinsurer-focused underwriting decisions and claims handling processes exist and current regulatory schemes do not address them. Yet they implicate issues of grave public policy. As described below, reinsurance clauses have been held valid so as to provide reinsurance for the bringing of a declaratory judgment action against the original insured to obviate coverage. Other approved clauses even allow for the reinsurance of judgments in excess of loss resulting from insurer bad faith and clauses which offer reinsurance for extracontractual damages arising from a bad faith tort suits. Each of these has the capacity to support rather than prohibit unfair insurance practices. If for no other reason than the moral hazard of reinsuring tortious conduct.

As regards declaratory judgments, many reinsurance agreements include a clause which states that the agreement covers "all expenses incurred in the investigation and settlements of claims or suits".¹⁹⁴ Such a clause makes sense in relation to the reinsurer's interest in not indemnifying claims beyond the scope of the policy they are reinsuring. These clauses have been construed to reinsure the cost of declaratory judgments brought against the primary insured policyholder to obviate coverage. To an extent, it makes sense for the reinsured to seek to lay-off these declaratory judgment costs to the reinsurer where much of the benefit of the coverage determination would accrue to the reinsurer on the risk. However, the availability of such coverage can only incentivize an increased use of the declaratory judgment mechanism. In fact, given the broad reaching good faith obligation of the reinsured, failure to bring the declaratory judgment action could potentially be seen as negligent.

These clauses are very common and often interpreted broadly.¹⁹⁵ Moreover, in the absence of an exclusion, the "standard practice" of the industry to allow for such costs can create a sufficient question of fact to

¹⁹⁴ See PLITT, *supra* note 9, at §9:29.

¹⁹⁵ See *Employers Ins. Co. v. American Reins. Co.*, 256 F. Supp.2d 923, 925-26 (W.D. Wis. 2003).

support an implied modification of the contract sufficient to defeat a motion for summary judgment.¹⁹⁶ Likewise, despite the absence of a clause, declaratory judgment costs have been upheld as part of the contract as a result of the parties “custom and practice”.¹⁹⁷

Other particularly worrisome reinsurance clauses implicate insurer bad faith. For example, one available clause makes reinsurance coverage available for judgments in excess of policy limits arising out of the reinsured’s bad faith failure to settle or defend a claim and another allows for reinsurance of bad faith judgments and other extracontractual damages. Called “judgment in excess of policy limits” and “extracontractual obligations” clauses, these provisions allow insurers to be indemnified for their own bad faith actions against their policy holders.

As reported in Ostrager & Newman’s Handbook on Insurance Coverage Disputes, a judgment in excess of policy limits clause generally provides “in word or substance”¹⁹⁸:

It is agreed that should the ceding insurer become legally obligated to pay a loss in excess of policy limits by reason of alleged or actual negligence, fraud or bad faith in rejecting an offer of settlement or in the defense or trial of any action against an insured, the Reinsurer agrees to assume _____% of said loss [in excess of the ceding insurer’s] \$ _____ retention.¹⁹⁹

These clauses are “relatively widely used and provide[] the reinsurer will participate in such excess verdicts but not to exceed the reinsurance contract limits”.²⁰⁰ Moreover, there are iterations of this clause which explicitly provide for coverage of “punitive damages”.²⁰¹ Other courts have found reinsurer’s liable for extracontractual damages even in

¹⁹⁶ See Premier Ins. Co. v. Hartford Accident & Indem. Co., 35 F. Supp. 2d 348, 351 (S.D.N.Y. 1999).

¹⁹⁷ See Affiliated FM Ins. Co. v. Constitution Reins. Corp., 416 Mass. *839, *846 (1994).

¹⁹⁸ See OSTRAGER & NEWMAN, *supra* note 10, at § 16.06[a].

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

the *absence* of such a clause, but where the reinsurance agreement does contain the common “follow the fortunes” language.²⁰²

The second bad faith related clause covering extracontractual obligations or ECO’s differs from that of the “excess judgments clause” in that it directly allows for reinsurance indemnification for tortious insurer bad faith awards.²⁰³ Its purpose has been described thusly:

When an insurance company finds itself on the wrong side of a bad faith case, a judgment awarding punitive damages often results and the insurance company must pay the judgment out of its own funds unless it has insured itself, through reinsurance programs or other means, against punitive damages awards. Many reinsurance agreements have a special provision called an extracontractual obligations clause, which typically provides that the reinsurer will pay some percentage of the reinsured’s liability for claims brought against it outside of the terms of underlying insurance contracts. It is well understood in the industry that the ECO clause is designed to respond to bad faith punitive damages awards against the reinsured.²⁰⁴

Prior to the creation of ECO clauses, the ability of insurers to lay-off the costs of their own bad faith actions had been limited to the availability of reinsurance for only judgments in excess of policy limits. The ECO clause sought to broaden this limitation by extending reinsurance for tortious bad faith judgments as well as judgments in excess of policy limits.²⁰⁵ ECO clauses offer reinsurance coverage for an insurer’s bad faith

²⁰² *Id.* (citing *Peerless Ins. Co. v. Inland Mut. Ins. Co.*, 251 F.2d 696, 697 (4th Cir. 1958)).

²⁰⁴ See Larry P. Schiffer & William Bodkin, *Caveat Reinsurer: Reinsuring Punitive Damages Under ECO Clauses*, 37 TORT & INS. L.J. 147 (2001).

²⁰⁵ *Id.* at 159. ECO clauses made their first appearance in 1978 in response to the desire of primary insurers to secure coverage for the various tort claims that had evolved into extracontractual, i.e., bad faith liability. Bad faith liability arises separately from the coverage provisions of any underlying insurance policy or reinsurance agreement, and results solely from the tortious conduct of an insurer in the course of policyholder service or claims handling under the policy. Tortious conduct may include: (1) denial of a claim based on inadequate investigation; (2) intentional misrepresentation of a claim or policy; (3) false accusations against the insured; (4) failure to disclose the rights of the insured; (5) unfair marketing practices; (6) unreasonable rejection of an offer within the policy limits; and (7) agent misrepresentation or fraud. An extracontractual obligation also may be a

liability sounding in tort law, rather than arising from breach of the insurance contract. Hence, the reinsurance clause which provides coverage for those tortious damages refers to such finding of liability as an “extracontractual obligation”. Such clauses first began to appear in 1978 as actions for tortious bad faith liability –and judgments- began to become more commonly accepted.

It appears obvious that the availability of reinsurance for bad faith tortious liability has the capacity to influence reinsured companies claims behavior. In fact, it appears to be an obvious moral hazard. A bad faith action can be grounded in a whole host of improper insurer activity when servicing a policyholder’s claim. As one commentator noted, examples of bad faith tortious conduct could well include:

(1) denial of a claim based on inadequate investigation; (2) intentional misrepresentation of a claim or policy; (3) false accusations against the insured; (4) failure to disclose the rights of the insured; (5) unfair marketing practices; (6) unreasonable rejection of an offer within the policy limits; and (7) agent misrepresentation or fraud.²⁰⁶

It seems apparent that so far as there is a regulatory interest in preventing bad faith insurer behavior – an interest reflected in both statutory and common law – the capacity to reinsure bad faith judgments has the capacity to subvert that interest.

Considering that reinsurance agreements are supported by the premiums charged to policyholders, it seems somewhat incongruous to allow the cost of insurer’s own bad faith judgments to be charged directly back to policyholders in their premiums. In fact, it seems to severely undermine the integral purpose of bad faith legal actions beyond the reinsured’s own retention, to allow for them to be reinsurable.

Clearly, this type of indemnification reduces the deterrent value of these actions. There can be little deterrence through litigation and the award of damages, tortious or otherwise, if those judgments are indemnified by reinsurer’s as a matter of course. Granted, reinsurers are sensitive to loss histories so too frequent a number of bad faith judgments could increase the insurer’s costs to reinsure. Still, that market based result seems somewhat less than the affect contemplated by legislators who enact bad faith statutes and somewhat disjointed from traditional understanding of the purpose of the tort system. In any event, these clauses identify yet

judgment in excess of the limits of an insurance policy, with the insured being liable for the excess due to the mishandling of the claim.

another possible contractual source of influence on reinsured's claims handling behavior.

V. CONCLUSION

Reinsurance agreements certainly have the capacity to influence insurer behavior. The effect of these agreements and the manner in which courts enforce their performance likely leads to the institutionalization of systems beyond and not necessarily congruent with many of the expectations and avowed purposes of some regulatory activity.

Insurance is often dubbed an industry affecting the public interest; if that is so, then reinsurance should acquire that denomination as well. Though silent, operating through private contract alone, it has the capacity certainly to influence, if not directly regulate, insuring behavior. To be effective, this Essay suggests that regulatory discussions of the insurance industry be expanded to recognize the influential capacity of the reinsuring industry. To fail to do so is to ignore a fundamental financial influence on the entire insurance industry with the likely result that the silent regulator will continue to operate below the notice of our sometimes raucous public ones.

**“FAIR IS FOUL AND FOUL IS FAIR:”
HAVE INSURERS LOOSENED THE
CHOKEPOINT OF COPYRIGHT AND
PERMITTED FAIR USE’S BREATHING
SPACE IN DOCUMENTARY FILMS?**

Thomas Plotkin^{*}
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I. INTRODUCTION

Historically, documentary films have served a public purpose, in that unlike standard Hollywood fare, they educate and convey news, criticism and commentary. The films shed light on lives that might otherwise remain obscure, or on corners of social and political interest that are unexamined by the mainstream media. Because of their capacity to convey a sense of unmediated reality, they exert enormous power over audiences. Documentarians routinely rely on copyrighted material in telling their stories. This appropriation can take the form of cultural artifacts captured incidentally while filming a subject, music or images included in the film to establish context, or other material used for critical or editorial purposes.

Copyrighted material is, by definition, protected by copyright. The Copyright Act, which has existed in one form or another since 1790 and has its own purpose adumbrated in Article I, section 8 of the Constitution, grants authors exclusive rights for a limited duration.¹ Copyright protection serves to incentivize the creation of knowledge-producing works, a public good. Infringement, the violation of those rights, is subject

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¹ U.S. CONST. art. I, § 8, cl. 8.

to substantial penalties, including statutory damages, attorney's fees, and a permanent injunction upon the work that was copied.

The Copyright Act of 1976 contains a counterweight to authors' rights: fair use.² Recognizing that new works come from old, and that the limited term of copyright protection signifies that the public benefit of knowledge-producing works may outweigh an author's exclusive rights, fair use permits the reasonable taking of copyrighted material for the purposes of criticism, comment, news reporting, teaching, scholarship or research.

In recent years, documentarians have found that the cost of licenses for copyrighted material has ballooned astronomically, far beyond the reach of their meager budgets. This is in large part because the large media entities that hold copyrights have awakened to the value of their back-catalogs as cash cows: since Hollywood and the music industry itself pays top dollar for licenses, documentarians are expected to as well. In addition, the ideological slant of many documentaries (historically oppositional), or the desire for brand-management on the part of the owner, often results in the denial of a license. Rights-holders have also been abetted by Congress' extraordinary expansion of the Copyright term, which in 1790 was fourteen years, but now effectively keeps anything created since the 1920's out of the public domain for generations.

Recognizing they sit on a goldmine, the media accordingly polices its copyrights aggressively, threatening documentarians who might take material with infringement suits. Even if a documentarian wins, these suits produce litigation expenses beyond most independent film-makers' means. Fair use provides little relief. The doctrine is an affirmative defense, only coming into play once a documentarian has been sued, leaving little room for informed decision-making at the time of the taking. Ex ante planning is also problematic because the Supreme Court has stated that fair use decisions must be made on a case-by-case basis, without regard to bright-line rules. The ensuing chaos in the lower courts renders the doctrine unpredictable and unstable.

Finally, documentarians require E & O insurance for their film to be distributed, screened or broadcast. Until early 2007, insurers either denied coverage for un-cleared material outright, or submitted the film to an unwieldy, ad hoc underwriting process when the film-maker sought distribution, when timeliness was most crucial. This underwriting process,

² Copyright Act of 1976, 17 U.S.C. § 107 (2009).

which already followed time-consuming failed attempts to clear the material, made documentarians reluctant to assert fair use.

The Copyright regime, considering the scale of its subject matter and the length and complexity of the Act, is largely a matter of private ordering. Enforcement lies with the courts, which may refine fair use ambiguities, but only when owners bring infringement suits and defendants assert fair use. Into this regulatory vacuum steps the insurer, who may acquire a regulatory role by virtue of its capacity to modify its insured's conduct. By exercising its gate keeping function to deter filmmakers from using un-cleared material or exercising fair use, insurers act as policeman for an owner-friendly copyright regime, abetting the monopolies in violating the spirit of the Copyright Clause, whose stated purpose is "the Progress of Science and the useful Arts;" that is, the public good.

Since February 2007, the insurer's regulatory role with respect to documentaries and fair use appears to have changed. The four major E & O insurers who serve documentarians have publicly embraced fair use, two of them offering affirmative endorsements. How this sea change came about, and what its effects may be, are the subject of this paper. Part II discusses copyright itself, from the dual incentivizing/knowledge-creating purpose in the Constitution, to its legislative expansion favoring owners at the public's expense. Part III discusses film-makers travails obtaining licenses, and the growth of the "content industry," the media monopolies who use their copyright protection to either extract exorbitant licensing fees, or withhold the material altogether. Part IV discusses the fair use doctrine, its common-law roots, statutory enactment, interpretation by the Supreme Court, and the nine fair use cases involving nonfiction film, which demonstrate the inconsistency and instability of the doctrine. Part V discusses the role of the E & O insurer in handling documentarians' fair use assertions prior to 2007. Part VI is a narrative of the events surrounding four insurers' public embrace of fair use for documentaries, assessing the differences in their underwriting approaches, and concluding with predictions for the future.

II. COPYRIGHT

A. THE CONSTITUTIONAL GRANT AS A SOCIAL BARGAIN - THE COPYRIGHT CLAUSE OR THE PROGRESS CLAUSE?

The power to create intellectual property rights is granted to Congress in Article I, section 8, clause 8 of the Constitution: "Congress has the power to promote the Progress of Science and the useful Arts, by

securing for limited Times to Authors and Inventors the exclusive rights to their respective Writings and Discoveries.” The Copyright Clause is the only enumerated Congressional power in Article I, Section 8 that has a stated purpose.³ Whereas the other enumerated powers flatly permit Congress to *do* some something (regulate commerce among the several states, declare war), here Congress is charged with advancing the production of knowledge.⁴

That purpose can be re-stated as the Congressional furtherance of three policies, whose priority may be divined from their ordering within the clause.⁵ First, the term “Science” in Enlightenment parlance was synonymous with “learning,” so, like copyright law’s English prototype the Statute of Anne, copyright exists to encourage learning.⁶ Second, the “limited times” allotted to copyright protection denotes the existence of a public domain, a future point when rights will no longer accrue to the author, and the public may exploit freely that for which it once needed permission.⁷ Third, within that limited term, the author will be vested with exclusive rights in her work, thus providing the incentive for the creation of new works.⁸

³ Lydia P. Loren, *Redefining the Market Failure Approach to Fair Use in an Era of Copyright Permissions Systems*, 5 J. INTELL. PROP L. 1, 3 (1997).

⁴ LAURENCE LESSIG, *FREE CULTURE: HOW BIG MEDIA USES TECHNOLOGY AND THE LAW TO LOCK DOWN CULTURE AND CONTROL CREATIVITY* 215 (2004).

⁵ Stacy McDonald, *Copyright for Sale: How the Commodification of Intellectual Property Distorts the Social Bargain Implicit in the Copyright Clause*, 50 HOW. L.J. 541, 546 (2007).

⁶ The Statute of Anne, enacted in 1710, was the first codification of copyright. It was subtitled “An Act for the Encouragement of Learning by Vesting the Copies of Printed Books in the Authors or Purchasers of such Copies . . . for the Encouragement of Learned Men to Compose and Write Useful Books.” Quoted in Anne E. Forkner et. al., *Pretty Woman Meets the Man Who Wears the Star: Fair Use After Campbell v. Acuff-Rose Music and American Geophysical Union v. Texaco*, 54 J. COPYRIGHT SOC’Y 719, 720 (2007).

⁷ McDonald, *supra* note 5, at 546.

⁸ *Id.* at 542, 546.

Prioritized in this manner, the third policy, the author's monopoly of exclusive rights in the work, is the means for achieving the first two, in that the monopoly temporarily rewards authors for their creations, then surrenders to the public access to, and use of, copyrighted works.⁹ Any private benefit an author gains through copyright protection is merely the vehicle by which a broader public interest is promoted.¹⁰

Laurence Lessig argues that in view of its singular Constitutional purpose, the Copyright Clause should instead be known as "the Progress Clause."¹¹ Some indication of the Framers' intent to avoid benefitting authors at the public's expense can be seen in the words of James Madison and Thomas Jefferson. Madison believed that copyright had the potential to thwart creativity while Jefferson believed that copyright protection is for the benefit of society overall, and not individual creators.¹²

Overall, it is clear from the congressional policies regarding the "copyright clause" that, at least initially, copyright protection was regarded as a protection for both authors and the general public.

B. THE LEGISLATIVE EXPANSION OF COPYRIGHT: FROM SOCIAL BARGAIN TO COMMODIFICATION

Congressional enactments from the 18th century down to the present day have shifted the Constitutional social bargain of copyright into the realm of a property regime.¹³ Propertization came to envelope copyrighted works within ownership terms of effectively unlimited duration which more closely resembled the exclusive rights granted to an owner of real property than the finite zone of protection envisaged by the Framers.¹⁴

⁹ *Id.* at 546.

¹⁰ Lee Ann W. Lockridge, *The Myth of Copyright's Fair Use Doctrine as a Protector of Free Speech*, 24 SANTA CLARA COMPUTER & HIGH TECH L.J. 31,38 (2007).

¹¹ LESSIG, *FREE CULTURE*, *supra* note 4, at 131-32.

¹² JAMES MADISON, *LETTERS AND OTHER WRITINGS OF JAMES MADISON* 427 (1884) (Philip R. Fendall ed., R. Worthington 1884).

¹³ McDonald, *supra* note 5, at 552.

¹⁴ *Id.* (quoting Michael A. Carrier, *Cabining Intellectual Property Through a*

The first Copyright Act appeared in 1790. Brief and straightforward, its scope was limited to maps, charts, and books, and granted authors exclusive rights to print, reprint, publish and sell them for a term of 14 years, renewable for 14 more.¹⁵ Registration was required, and infringement triggered statutory penalties.¹⁶ In the next 119 years, the Act was amended to expand the subject matter of copyright (encompassing musical compositions, photographs, paintings, drawings, chromolithographs, statues, and works of fine art), as well as the initial term, which in 1831 was raised from 14 to 28 years.¹⁷

The Copyright Act of 1909 substantially revised the original statute, increasing its length from 7 to 64 sections.¹⁸ Copyright's subject matter was expanded to encompass public performance and derivative works (the latter defined non-exhaustively as compilations, abridgements, arrangements, dramatizations, and translations of copyrighted works).¹⁹ In addition, the renewal term was extended to 28 years, bringing the total term of copyright to 56 years.²⁰ More significantly, corporate copyright was created, vesting authorship in an owner who contracted a creator to produce a work for hire.²¹

Congress next re-visited the Copyright Act in 1976; in the intervening seven decades, motion pictures, radio, recorded music, and television and the nascent computer software industry had matured into the mass media environment we live in today.²² The new Act now spanned

Property Paradigm, 54 DUKE L.J. 1, 4 (2004)).

¹⁵ Joseph P. Liu, *Regulatory Copyright*, 83 N.C. L REV 87, 94 (2004).

¹⁶ *Id.*

¹⁷ *Id.* at 95.

¹⁸ *Id.* at 94-96.

¹⁹ *Id.* at 96.

²⁰ *Id.*

²¹ SIVA VAIDHYNATHAN, COPYRIGHTS AND COPYWRONGS, 102, 214, n. 33 (2003) (quoting Copyright Act of 1909, § 23).

²² Amendments to the 1909 Act in the 1920's included recorded music and motion pictures as protected under copyright. 17 U.S.C. § 102(a)(6)-(7) (2006).

several hundred pages, dwarfing its predecessors in complexity.²³ It should come as no surprise that the Act was the product of over twenty years of negotiations with representatives of a burgeoning culture industry, and that the Act substantially expanded the scope and terms of copyright protection.²⁴

The exclusive rights of the author now protected “all original works of authorship fixed in a tangible medium expression” from unauthorized reproduction, distribution, public performance, and public display.²⁵ The term of copyright was extended yet again, this time for the life of the author, plus fifty years.²⁶ Corporate copyrights were extended to seventy five years.²⁷ The civil penalties for copyright violation were set at between \$750,000 and \$30,000 per infringement, with courts given discretionary authority to raise that to \$150,000 per infringement, if willfulness was found.²⁸ Additionally, default copyright was adopted, as all renewal formality requirements were dropped for works created before 1978.²⁹ The necessity that copyrighted works be registered and renewed prior to 1976 as a de facto matter placed the vast majority of works into the public domain after the initial term had lapsed.³⁰ Now, no action beyond

²³ Liu, *supra* note 15, at 99.

²⁴ See generally JESSICA LITMAN, DIGITAL COPYRIGHT 48-58 (2001).

²⁵ Copyright Act of 1976, Pub. L. No. 94-533, § 102(a), 90 Stat. 2541, 2544-45 (1976) (codified at 17 U.S.C. § 102(a)(2000)).

²⁶ Copyright Act of 1976, Pub. L. No. 94-533, § 302(a), 90 Stat. 2572 (codified as amended at 17 U.S.C. § 302(a) (2000)); McDonald, *supra* note 5, at 548.

²⁷ Copyright Act of 1976, Pub. L. No. 94-533, § 302(c), 90 Stat. 2572 (codified as amended at 17 U.S.C. § 302(c) (2000)); LESSIG, FREE CULTURE, *supra* note 4, at 135.

²⁸ Digital Theft Deterrence and Copyright Damages Improvement Act of 1999, Pub. L. No. 106-160, 113 Stat. 1774 (codified at 17 U.S.C. § 504(c) (2004)).

²⁹ LESSIG, FREE CULTURE, *supra* note 4, at 135.

³⁰ John Tehranian, *Infringement Nation: Copyright Reform and the Law/Norm Gap*, 2007 UTAH L. REV. 537, 548 (2007).

the mere creation of the work was needed to trigger infringement enforcement.³¹

The relatively brief term of copyright protection allotted by earlier iterations of the Act was consistent with the fact that most creative works have a brief commercial existence.³² The combination of limited terms of protection with formalities requiring registration and renewal ensured that works no longer being exploited passed into the public domain.³³ Under the extended terms and relaxed registration and renewal formalities of the Copyright Act of 1976,, works that hitherto might have been made freely available sooner became profitable to corporate owners via the threat of an infringement suit, both by reason of “the long tail” of copyright protection and the slide from a default regime of non-protection to one of per se protection.³⁴

Congress was still not through with tinkering with copyright, and further changes nakedly reflected the influence of industry lobbying. In 1998, with the passage of the Copyright Term Extension Act (CTEA), the copyright term was extended an additional twenty years. This brought the term for new and subsisting works up to the life of the author plus seventy years, and in the case of a work made for hire, ninety-five years from the year of first publication or 120 years from the year of creation, whichever expires first.³⁵

CTEA was nominally passed to harmonize United States copyright law with its European Union counterpart, which established a term of life plus seventy years and denied this longer term to works of non-E.U. origin

³¹ *Id.*

³² LESSIG, *FREE CULTURE*, *supra* note 4, at 134.

³³ *Id.* at 135. Lessig states that in 1973, more than 85 percent of copyright owners failed to renew their copyrights, which means the average term of copyright in that year was 32.2 years; with the elimination of the renewal requirement, the average term becomes the maximum term, which, in 2003 had tripled from 32.2 years to 95 years. *Id.*

³⁴ Tehranian, *supra* note 30, at 548.

³⁵ Sonny Bono Copyright Term Extension Act, Pub. L. No. 105-298, 112 Stat. 2827 (1998) (codified at 17 U.S.C. § 302(a) (2000)); McDonald, *supra* note 5, at 556.

unless the foreign law provided the same protection.³⁶ However, harmonization could have been accomplished by reciprocal extension of E.U. works copyright terms within the U.S.³⁷ The bill's legislative history manifested Congressional concern that the term extension was necessary to preserve the dominance of the U.S. culture industry, with scant mention of the preservation of the social bargain of copyright envisioned by the Framers.³⁸ In fact, it has been widely reported that the bill was a direct response to intense lobbying by Walt Disney Studios, who were faced with loss to the public domain of Mickey Mouse, Donald Duck and their kin in 2003 unless Congress extended the term.³⁹ For this reason, CTEA has been called "a classic instance of almost pure rent-seeking legislation."⁴⁰

Justice Stephen Breyer has noted that as a practical matter, CTEA's long tail of copyright protection imposes a "permissions requirement . . . [upon those] who want to make the past accessible for their own use or for that of others," because with the lengthened term comes the lengthened life of the licenses attached to that term.⁴¹ Breyer argued that the prohibitive cost that those licenses imposed on users would affect "historians, scholars, writers, artists ... and researchers of all kinds" for decades to come;

³⁶ McDonald, *supra* note 5, at 556.

³⁷ *See id.* at 556-57.

³⁸ *Id.* at 557. The most notorious expression of these sentiments came from Mary Bono, widow of Representative Sonny Bono and successor to his seat in the house upon his death. She stated that "Sonny wanted the term of copyright protection to last forever. I am informed [...] that such a change would violate the Constitution... As you know, there's Jack Valenti's proposal for term to last forever less one day." *Id.* (Valenti was the first president of the Motion Picture Association of America, the movie industry's lobbying group).

³⁹ Chris Sprigman, The Mouse That Ate the Public Domain: Disney, the Copyright Term Extension Act, and *Eldred v. Ashcroft* (Mar. 5, 2002), http://writ.news.findlaw.com/commentary/20020305_sprigman.html.

⁴⁰ Robert Merges, *One Hundred Years of Solicitude: Intellectual Property Law*, 88 CAL. L. REV. 2187, 2236 (2000).

⁴¹ *Eldred v. Ashcroft*, 537 U.S. 187, 250 (2003) (Breyer, J., dissenting). *Eldred* was a failed constitutional challenge to the CTEA. *Id.* at 771-72.

additionally, he predicted that this would hinder or prevent the use of old works as the costs of obtaining permission has risen drastically.⁴²

The negative effects of a restrictive owner-friendly copyright system and its corollary, the all-encompassing permissions system which Breyer warned of, is best seen than in its effects on documentary filmmakers.

II. THE DOCUMENTARIAN'S DILEMMA: CREATIVE ENDEAVOR STIFLED BY CLEARANCE CULTURE

A. "HAPPY BIRTHDAY," THE TEXTURE OF THE REAL, AND THE HIGH COST OF CLEARANCE

The song "Happy Birthday to You" was copyrighted by schoolteachers Mildred and Patty Smith Hill in the mid-1930's.⁴³ Under the Copyright Act of 1909, controlling at the time the Hill sisters registered their work, the song would have fallen into the public domain after one 28 year term, unless it was renewed for an additional 28 year term.⁴⁴ But the Copyright Act of 1976 granted the owners an additional 19 years of protection.⁴⁵ Then CTEA added 20 more years of exploitation to the life of "Happy Birthday." Music publishing giant Warner Chappell bought the rights in 1989.⁴⁶ The song nets around \$2 million annually in royalties.⁴⁷ At the time of the acquisition, rumored to have cost \$25 million, a Warner Chappell executive admitted that motion picture and television licensing

⁴² *Id.* at 250-52

⁴³ K. Matthew Dames, *Copyright Conundrum: Documentaries and Rights Clearance*, INFO. TODAY, June 2006, at 26.

⁴⁴ Copyright Act of 1909, ch. 320, § 23, 35 Stat. 1075, 1080 (1909) (repealed 1976).

⁴⁵ Copyright Act of 1976, 17 U.S.C. § 304(b) (1976) (current version at 17 U.S.C. § 304(b) (2000)).

⁴⁶ Assoc. Press, "*Happy Birthday*" and the Money it Makes, N.Y. TIMES, Dec. 26, 1989, at C26.

⁴⁷ *Id.*

was the motive, saying “Obviously whenever there’s a birthday scene, they’re going to use that song.”⁴⁸ Warner Chappell Music and the Hill estate stand to collect royalties from “Happy Birthday” until 2030, barring an additional expansion of the copyright term by Congress.

“Happy Birthday” is the *bete noir* of documentarians: wedded to the texture of our everyday lives, it is predictable that a director following live subjects may stumble upon a birthday party, and the moment when “Happy Birthday” is sung could constitute a privileged event in the film. One such scene occurs in *Hoop Dreams*, when one of the film’s subjects, a teenager from Chicago’s housing projects chasing the dream of college basketball as a way out of the mean streets, is thrown a birthday party; the song is sung, and his mother says offhandedly, “Isn’t it wonderful that he made it to 18?”⁴⁹ Director Peter Gilbert called this a “pivotal scene” in the Oscar-winning documentary.⁵⁰ He also described the owners as “brutal” in exacting clearance, demanding \$15,000-\$20,000 for one verse.⁵¹

Even a historical documentary can fall into the “Happy Birthday” money pit. In *Eyes on the Prize*, there is an excerpt of home-movie footage of a birthday party thrown for Dr. Martin Luther King by his staff, where “Happy Birthday” is sung.⁵² The films’ clearance budget was so tight that the producers had to weigh paying a substantial amount of money for the song against dropping a valuable glimpse into King’s private life, as the scene would lose meaning if the song were cut.⁵³

Examples abound of filmmakers capturing copyrighted material felicitously, seeing that its presence adds something aesthetically to the scene, and then being faced with the choice of paying an exorbitant

⁴⁸ *Id.*

⁴⁹ PATRICIA AUFDERHEIDE & PETER JASZI, UNTOLD STORIES: CREATIVE CONSEQUENCES OF THE RIGHTS CLEARANCE CULTURE FOR DOCUMENTARY FILMMAKERS 11 (2001), http://www.centerforsocialmedia.org/files/pdf/UNTOLDSTORIES_Report.pdf.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Dames, *supra* note 43, at 24.

⁵³ *Id.* at 27.

licensing fee or leaving it on the cutting-room floor. In *Mad Hot Ballroom*, a film about urban public school fourth graders who enter a ballroom dancing competition, the camera caught a boy going home from school with his mother.⁵⁴ She had just asked how his day had gone, when her cell phone rang, and she answered before he could respond.⁵⁵ The producer said the moment “was such an indicator of today’s culture ...The look on his face says ‘I don’t get to tell my mom about my day.’”⁵⁶ Adding an additional layer of irony, the ring-tone on the mother’s phone was the theme song from *Rocky*; this, in a true-life *Rocky* about underdog Brooklyn kids competing in a city-wide ballroom dancing competition.⁵⁷ EMI Music Publishing, the rights-holder to the *Rocky* theme, demanded \$10,000 for the documentarian’s use of six seconds of music.⁵⁸ However, after months of begging, the producer got them down to \$2,500; this on a film whose total music clearance costs were \$170,000 of a \$500,000 budget.⁵⁹ In *Sing Faster*, in a backstage view of a production of Wagner’s *Ring of the Niebelung* the camera caught stage-hands playing checkers while watching *The Simpsons* on television., oblivious to the opera performance occurring in the background.⁶⁰ The *Simpsons* clip was onscreen for four-and-a-half seconds.⁶¹ The image was a perfect collision of high and low culture, and it did not make it into the finished film. Matt Groening, the *Simpsons* creator granted Else permission to use the clip, but advised to him to call the Fox network, which airs the show.⁶² Else was surprised to discover that

⁵⁴ Nancy Ramsey, *The Secret Cost of Documentaries*, N.Y. TIMES, Oct. 16, 2005, at A13.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ LAWRENCE LESSIG, *FREE CULTURE*, *supra* note 4, at 95-96 (2004).

⁶¹ *Id.* at 96.

⁶² *Id.*

Groening didn't actually own the rights to the show, and that his permission was no good.⁶³ Fox demanded a \$10,000 licensing fee for the 4.5 seconds.⁶⁴ Convinced there was a mistake, Else asked if he could get the educational rate, and was informed \$10,000 *was* the educational rate.⁶⁵ Else digitally replaced *The Simpsons* footage with a shot from one of his own documentaries.⁶⁶

Historical and political documentaries, where copyrighted material is edited into a mosaic rather than caught on the fly, are also vulnerable to the vagaries of copyright.⁶⁷ A documentarian making a film about Hollywood representations of the Holocaust required an hour of clips from movies.⁶⁸ The rights costs wound up tripling the entire production budget, even after he received discounts from sympathetic studio executives.⁶⁹ The producer's argument that long-forgotten films languishing in the licensors' libraries might enjoy a renewal of interest by being featured in the documentary left the licensors unmoved.⁷⁰

Antipathy to the historical documentarian's message can be a deal-breaker for owners. For his documentary *Uncovered: The Whole Truth About the Iraq War*, partisan political filmmaker Robert Greenwald wanted to use a clip of President George W. Bush doing a poor job of defending his decision to invade Iraq in an appearance on *Meet the Press*.⁷¹ NBC denied permission to use the clip, even when full compensation was

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ LESSIG, *supra* note 4, at 97.

⁶⁷ See generally AUFDERHEIDI & JASZI, *UNTOLD STORIES*, *supra* note 49.

⁶⁸ *Id.* at 14.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Lawrence Lessig, *Copyrighting the President*, WIRED MAG., Aug. 2004, available at <http://www.wired.com/wired.archive/12.08/view.html?pg=5>.

offered, on the grounds that the clip was unflattering to the President.⁷² The film *Smoke and Mirrors* illustrated collusion between the tobacco industry and Hollywood by showing clips from old movies glamorizing smoking by depicting the biggest stars puffing away on cigarettes in scene after scene.⁷³ The standard form licensing agreements issued by all the studios forbid any use criticizing the studio, its producers, employees, or the motion picture industry itself, rendering the clips off-limits.⁷⁴ As this article goes to press, Yoko Ono is seeking an injunction to prevent a documentary that touts “intelligent design” and disparages the teaching of evolution from critically deploying John Lennon’s song “Imagine” in the film and using it without permission (“Imagine no religion....”).⁷⁵

Finally, at least one film of vast significance was nearly lost completely due to restrictive clearance procedures. *Eyes on the Prize* is an epic multi-part historical documentary chronicling the Civil Rights Movement. Produced independently, it aired in eight parts on PBS in 1987, followed by six additional segments in 1990, to high ratings and massive acclaim.⁷⁶ *Eyes* was an extremely important documentary, important for both its scope and its content.

The film was partially composed of interviews with participants in the Civil Rights Movement, and partially compiled from archival and news footage, containing 492 minutes culled from 80 archives and 272 still photographs.⁷⁷ For the soundtrack, 120 songs were licensed.⁷⁸ Each

⁷² *Id.*

⁷³ Telephone Interview with Michael Donaldson, Donaldson and Callif (Sept. 12, 2007).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Henry Louis Gates, chairman of the department of African American Studies at Harvard University called *Eyes* “the most sophisticated and poignant documentary of African-American history ever made.” Nancy Ramsey, *The Secret Cost of Documentaries*, N.Y. TIMES, Oct. 16, 2005, at A13. Jon Else, who edited the series, called it “virtually the only audio-visual purveyor of the history or the civil rights movement in America.” AUFDERHEIDE & JASZI, *UNTOLD STORIES*, *supra* note 49, at 19.

⁷⁷ Nancy Ramsey, *The Hidden Cost of Documentaries*, N.Y. TIMES, Oct. 16,

episode was about 50% archival, and derived from commercial sources.⁷⁹ Due to budget constraints, the clips were licensed for differing terms, some in perpetuity, some for terms of three, seven, and ten years.⁸⁰ When the terms began to expire, the film had to be pulled from circulation.⁸¹ The last broadcast before it disappeared from view was in 1993.⁸² Video tapes were available, sold largely to libraries and schools shortly after the initial broadcasts.⁸³ Since that final broadcast, video tape was the only way to see the film, yet video tapes break easily, degrade rapidly with use and age, and are subject to loss and theft.⁸⁴

By 2006, *Eyes on the Prize* had become a lost film, unavailable on DVD, the VHS tapes crumbling and disappearing, commercial sale of the tapes ceased long ago due to the lapse of licenses, and exhibition or broadcast in any venue legally impossible.⁸⁵ An entire generation of

2005, at 2.13.

⁷⁸ Dames, *supra* note 43, at 27.

⁷⁹ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 19.

⁸⁰ Ramsey, *supra* note 77. The cost of archive footage at \$3,500-\$4,500 a minute has been described by one filmmaker as “extortionate.” AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 9.

⁸¹ Ramsey, *supra* note 77.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ Dames, *supra* note 43, at 24.

⁸⁵ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 19. In 2005, following substantial outcry in the media and bootleg copies surfacing both in theaters and the internet, the Ford Foundation kicked in \$600,000 to pay new licensing fees. Katie Dean, *Cash Rescues Eyes on the Prize*, WIRED MAG., Aug. 30, 2005, available at <http://www.wired.com/entertainment/music/news/2005/08/68664>. In October 2006 the series was broadcast on PBS for the first time in 15 years, and soon after the series became available on DVD for educational markets only at a cost of \$375. PBS, <http://www.pbs.org/wgbh/amex/eyesontheprize/> (last visited Feb. 23, 2009); Hamil R. Harris, *Activists Mark Rerelease of ‘Eyes on the Prize’*, WASH. POST, Nov. 16, 2006, available at

students had been deprived of the chance to see this landmark film, and it appeared that *Eyes on the Prize* would go missing for ever.

All of these examples of clearance issues not only speak to the hazards of filmmakers' use of copyrighted material, they also illustrate how integral such material can be for the purposes of creating the documentary. Copyrighted material can find its way into a documentary incidentally, when the recording apparatus captures a work of art hanging on a wall, or something playing on a TV or radio, or a boombox blaring near a subject, or a subject performing a song. Such uses are part and parcel of the reality being captured, and as such can convey the dense texture of that reality by placing the subjects amidst the cultural artifacts they live amongst, or, when the filmmaker gets truly lucky, adding a felicitous counterpoint and commentary to a scene.

Copyrighted materials may be collaged into a work deliberately as well as merely captured. A film describing an historical event or a matter of current public import gains power and resonance when archival or news footage is employed, rather than just giving a dry oral recitation of the facts. Cultural artifacts culled from mass media, such as advertisements and scenes from movies and television programs, can provide necessary context to back up a critique of the norms which produced the artifacts. Music, which arguably elicits even more powerful audience associations and emotions than images, can provide a similar function; songs can situate an audience in the historical or cultural moment it evokes, tell us something about the environment the subject lives in, or lend commentary or an ironic counterpoint to the visuals. In any of these instances, a picture, or a piece of music, can be worth a thousand words.

But as we have seen from the examples above, documentarians' use of other authors' copyrighted material can be so costly as to be prohibitive, and in some instances may be rendered impossible by the owner's refusal to license the work at any price. It must be borne in mind that most documentary films budgets are low, and often rely on public and non-profit funding until they are acquired post-production: their very cheapness is one source of their attractiveness to the broadcasters and

<http://www.washingtonpost.com/wp-dyn/content/article/2006/11/15/AR2006111500588.html>. Presumably, widespread commercial sale at a cheaper price through standard retail outlets may still be restricted by unresolved clearance issues.

theatrical distributors who have embraced them so zealously in the last decade.⁸⁶

A documentarian's use of copyrighted material breeds delays and expense from pre-production until years after the film's completion, indeed for as long as the material remains under copyright. Licensing fees are often inflated by standard "most favored nation" clauses in licensing agreements, mandating that all rights holders get the highest price negotiated by any other; thus the fees for copyrighted music and images used in a documentary may be determined by a single exorbitant quote, and often the film-maker's budget is uncertain until the time that high quote comes in.⁸⁷ The result can either be an untenable budget, or dropping the most expensive element, no matter how important it may be to the film.⁸⁸

In addition, rights must be cleared anew for each distribution channel – telecast, cable, theatrical, DVD, internationally.⁸⁹ A documentary producer who made a film about Los Angeles' specialty cinephile cable station Z Channel, the precursor to HBO,⁹⁰ relied heavily on clips from 53 movies; initially intended solely for broadcast on the Independent Film Channel, increasing interest in the film necessitated repeat negotiations with the studios as its exhibition prospects broadened.⁹¹

⁸⁶ Gretchen Stoeltje, *Light in Custody: Documentary Films, the TEACH Act and the DMCA*, 20 SANTA CLARA COMPUTER & HIGH TECH. L.J. 1075, 1079-80 (2004). And as documentarian Frederick Wiseman said of Hollywood budgets, "You [a documentarian] could make five films for the lunch money." Janet Maslin, *Summer Films: Indies; Visionaries With Their Eyes on the Truth*, N.Y. TIMES, May 2, 1999, at A2, available at <http://query.nytimes.com/gst/fullpage.html?res=9506E2DD153DF931A35756C0A96F958260>.

⁸⁷ AUFERHEIDE & JASZI, *UNTOLD STORIES*, *supra* note 49, at 12-13.

⁸⁸ Kimberly Brown, Copyright vs. Creativity, Realscreen, June 1, 2005, available at <http://www.realscreen.com/articles/magazine/20050601/copyright.html?word=Copyright&word=vs.&word=Creativity>.

⁸⁹ See Paul Cullum, *Freedom of Information: Copyright and its Discontents*, L.A. WEEKLY, Aug. 17, 2006, available at <http://www.lawweekly.com/2006-08-17/film-tv/freedom-of-information>.

⁹⁰ Internet Movie Database, Z Channel: A Magnificent Obsession (2004), available at <http://www.imdb.com/title/tt0405496/>.

⁹¹ Cullum, *supra* note 89.

First the clips had to be cleared for North American cablecast; then, when the film was entered into the Cannes Film Festival in competition, the filmmaker needed “festival rights;” next, to qualify for an Academy Award nomination, the film had to have a limited theatrical release, requiring a new round of clearances; and finally, international television and worldwide DVD rights had to be cleared.⁹² Of course, the same steps had to be repeated for any soundtrack music from the clips, with separate negotiations for the actual recording and the publishing rights.⁹³ Following these travails, producer Evan Shapiro vowed never again to make a clip-heavy documentary.⁹⁴ Overall, the combined television and DVD rights came to the nominal fee of \$375,000.⁹⁵ (This was with substantial assistance from two sympathetic studios which cut favorable deals). However, it should be noted that even three years later the producer was still paying for and clearing film clips;⁹⁶ this is evidence of the complexity of attaining adequate licensing rights for a production.

Inability to pay for licenses results in the loss of crucial material within a film, or even the disappearance of an existing film, such as *Eyes on the Prize*. There are less readily quantifiable losses to the culture as well; for example, the phenomenon of “untold stories,” films that go unmade because the film-maker has realized that her concept will likely be impossible to finance due to a dependence on copyrighted material.⁹⁷ Because of rising clearance costs, producers and copyright lawyers alike have stated that archive-dependent historical films like *Eyes on the Prize* and PBS’s similarly exhaustive 1983 series *Vietnam: A Television History*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Elaine Dutka, *No Free Samples for Documentaries: Seeking Film Clips With the Fair-Use Doctrine*, N.Y. TIMES, May 28, 2006, available at <http://www.nytimes.com/2006/05/28/movies/28dutr.html>.

⁹⁵ A single clip from a Hollywood studio film can cost \$7000 for broadcast clearance alone. AUFERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 19.

⁹⁶ Cullum, *supra* note 89.

⁹⁷ AUFERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 11, 13, and 23.

could not be made today,⁹⁸ and that documentaries that use Hollywood film clips have “become almost impossible.”⁹⁹

B. THE CONTENT INDUSTRY AND THE RISE OF CLEARANCE
CULTURE

Film-makers interviewed by the Center for Social Media in 2005 asserted that rights costs accounted for more of their budgets than a decade earlier, and that the process had become both more time-consuming and more costly in legal fees than hitherto.¹⁰⁰ The reasons for this increase are multiple, and interlinked.

Cultural activists have labeled the combined forces of the movie studios, TV networks, recording and publishing fields as “the content industry.”¹⁰¹ These businesses are thought of as simply content-producers, delivering to the marketplace a steady stream of new TV shows, movies, CD’s and books. However, they have gradually metamorphosed in the last two decades into something not quite so simple.

Authors of original works of the type that documentarians appropriate – films, music, television shows, journalism – typically do not control the copyrights of their work.¹⁰² Most of these works were made for hire, and the corporate media entities that commissioned the work holds the copyright and control every subsequent use of the work.¹⁰³ The content industry is a high-volume business, but there are a few players controlling the vast majority of copyrighted sounds and images.¹⁰⁴ This is the result of several decades of increased concentration of media ownership, as these corporations have consolidated into an ever-shrinking number of large

⁹⁸ See Ramsey, *supra* note 54; Brown, *supra* note 88.

⁹⁹ Brown, *supra* note 88.

¹⁰⁰ AUERHEIDE & JASZI, UNTOLD STORIES, *supra* note 85, at 7-8.

¹⁰¹ McDonald, *supra* note 5, at 543 n. 15.

¹⁰² *Id.* at 554.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

conglomerates controlling an ever-growing volume of copyrighted material.¹⁰⁵

The growth of the content industry has coincided with the appreciation in value of the deep catalog of already-distributed copyrighted works whose shelf-life has theoretically passed.¹⁰⁶ Content producers that once made money by creating new programming, films and music discovered that their back catalogs as a significant revenue stream, and have become content-recyclers.¹⁰⁷ As copyright attorney/law professor Peter Jaszi has said, what was once seen as “marginal, unimportant, and secondary has suddenly become a big focus of private and public attention.”¹⁰⁸ One media liability insurance broker has likened the response of the content industry to the value of long-dormant libraries as realization that it was “sitting on a gold mine.”¹⁰⁹

As a consequence, copyright ownership and enforcement is now policed more aggressively than twenty years ago; this policing, as the examples of film-makers’ struggles above indicates, extends to documentarians.¹¹⁰ Nonfiction filmmakers have in part been a victim of

¹⁰⁵ *Id.* Senator John McCain, summarizing the FCC’s data compiled in its review of media ownership, stated “Five companies control 85 percent of our media resources.” Quoted in LESSIG, *FREE CULTURE*, *supra* note 4, at 162. Lessig further provides concrete examples: five recording labels control 84.8 percent of the U.S. market. *Id.* Rupert Murdoch’s News Corp. is a fully integrated vertical monopoly, in that it supplies content via the Fox movie studio and Fox broadcast and cable network, controls sports broadcasts and newspaper and book publishing, sells its content to the public and advertisers in print, broadcast and cable media, and operates the distribution channels through which the content is disseminated via movie theaters and television venues, as well as through satellite systems it owns in the U.S., Europe, and Asia. *Id.* at 163.

¹⁰⁶ See MARJORIE HEINS & TRICIA BECKLES, BRENNAN CTR. FOR JUSTICE, *Will Fair Use Survive? Free Expression in the Age of Copyright Control* 5- 6 (2005), available at <http://www.fepproject.org/policyreports/WillFairUseSurvive.pdf>.

¹⁰⁷ *See id.*

¹⁰⁸ Brown, *supra* note 88.

¹⁰⁹ HEINS & BECKLES, *supra* note 106, at 6.

¹¹⁰ Paige Gold, *Fair Use and the First Amendment: Corporate Control of Copyright is Stifling Documentary Making and Thwarting the Aims of the First*

their own success and heightened visibility; the high grosses of films like *An Inconvenient Truth* (\$24,540,079 domestic box office), the works of Michael Moore (\$265,310,868 combined for *Sicko*, *Fahrenheit 911*, and *Bowling for Columbine*), and *Supersize Me* (\$11,536,423) have not only permitted audiences, theater chains and distributors to view documentaries as entertainment, but copyright holders have made the leap as well.¹¹¹ So, a connection can be drawn between the music publisher's \$10,000 demand for the use of a few seconds worth of the *Rocky* theme incidentally captured in a low-budget documentary, the success of documentaries at the box office, and the content producers new-found role as licensors of accumulated copyrights. As Professor Jaszi has said, "Would music copyright owners 10 years ago have predicted they'd be making a substantial part of their money over ringtones on cellphones?"¹¹²

Movie studios, TV networks, and the music industry are only the most conspicuous forces driving up clearance costs. Archive houses preserve and store old newsreel and other functional nonfictional footage, and their product can be essential to historical documentaries. They have also been the locus of an inflationary spiral in recent years. Archive houses were once small, independent operations that negotiated with impecunious documentarians on a hand-shake basis.¹¹³ Today, the small houses have been gobbled up by larger ones, mirroring larger trends in media consolidation, and the licensing fees they charge, which can run as high as

Amendment (bepress Legal Series, Working Paper No. 950, 2006), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=4599&context=expresso>.

¹¹¹Ramsey, *supra* note 54. Top Documentary Box Office Grosses, available at <http://www.boxofficemojo.com/genres/chart/?id=documentary.htm> (last visited 3/23/09). Documentary box office grosses should be scrutinized relative to what top-grossing studio fare takes in. The highest-grossing documentary, *Fahrenheit 911*, made \$119,194,771 on its theatrical release. *Id.* The highest grossing Hollywood feature, *Titanic*, took in almost \$601 million. *Id.* *Fahrenheit 911* ranks at number 295 on the all-time domestic box office scale, and it must be born in mind that no other documentary even comes close to that figure. *Id.*

¹¹²Ramsey, *supra* note 54. Sasha Frere-Jones, *Ring My Bell: the Expensive Pleasures of the Ring Tone*, NEW YORKER, March 7, 2005, available at http://www.newyorker.com/archive/2005/03/07/050307crmu_music.

¹¹³AUFERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 8-9.

\$3,500-\$4,500 a minute, have been called by one documentarian “extortionate.”¹¹⁴ Moreover, the explosion of specialty cable channels, owned by major media conglomerates (and hence well-funded, unlike typical documentaries) produces a never-ending stream of sports, nature, and historical shows that have so increased the demand for archival footage that licensing costs have risen accordingly. The “gold mine” effect of the value of the back catalog, familiar from film clips and popular music, has occurred in the less overtly-commercial context of archive footage.¹¹⁵

Licensing practices between the big media entities also drive up the costs of clearance.¹¹⁶ The same media corporations who demand exorbitant fees from documentarians also pay high fees themselves for any uses of copyrighted materials in their own original work.¹¹⁷ Movie studios and networks are naturally conservative when it comes to courting infringement suits, as they are large institutions with deep pockets, and their lawyers are well aware that such entities are attractive lawsuit targets.¹¹⁸ Studio legal departments often impose in-house guidelines on their producers, mandating that the producers clear everything; adherence to these guidelines is a defensive litigation-avoidance strategy.¹¹⁹ Accordingly, studios mechanically pay high licensing fees, and bequeath an industry custom and fee structure to impecunious documentarians, who do not have comparable resources for clearance costs.¹²⁰

It is this asymmetry between the big media players who can afford to clear everything, and do clear everything, and the documentarian who would clear everything but will never have the budgetary means to do so,

¹¹⁴ *Id.* at 14 (quoting Jeffrey Tuchman).

¹¹⁵ Brown, *supra* note 88.

¹¹⁶ See James Gibson, *Risk Aversion and Rights Accretion in Intellectual Property Law*, 116 YALE L.J. 882, 901 (2006).

¹¹⁷ See *id.* at 901-902.

¹¹⁸ MICHAEL DONALDSON, CLEARANCE & COPYRIGHT 222 (2003).

¹¹⁹ Jennifer E. Rothman, *The Questionable Use of Custom in Intellectual Property*, 93 VA. L. REV. 1899, 1922 (2007).

¹²⁰ DONALDSON, *supra* note 118, at 222.

that renders industry practices problematic. The better-financed private interests, such as movie studios, will have the copyrighted material of others available when needed to further its creative work, but a less powerful actor, such as a documentary filmmaker, will not.¹²¹

And yet, ironically, documentarians who seek clearance for their use of copyrighted material may often not even have to seek such clearance. Section 107 of the same Copyright Act of 1976 that reaffirms exclusive rights to the content industry also provides the nonfiction filmmaker with a fair use defense.¹²²

III. FAIR USE

A. THE DOCTRINE AND ITS ENACTMENT

Fair use is a limitation on copyright protection that acknowledges that not every secondary use is an infringement upon an owner's exclusive statutory rights.¹²³ Consistent with the idea of copyright's social bargain, the doctrine permits a user to appropriate elements of a copyrighted work without express permission, in recognition that new works necessarily draw on old works.¹²⁴ Fair use enables the creation of new works that surpass the original work, augmenting our culture and our knowledge in a manner that the original does not.¹²⁵ By refusing to label a transformative¹²⁶

¹²¹ In addition, documentarians themselves benefit from the same copyright protection that creates their own clearance headaches. In recognition of this, they tend to acquiesce in the face of a rightholder's demands, as they recognize the possibility of a situation where the shoe could be on the other foot. See AUFDERHEIDE & JASZI, *UNTOLD STORIES*, *supra* note 49, at 22-23.

¹²² Copyright Act of 1976, 17 U.S.C. § 107 (2006).

¹²³ See Forkner, *supra* note 6, at 722-23.

¹²⁴ Jeannine M. Marques, *Fair Use in the 21st Century*: Bill Graham and Blanch v. Koons, 22 BERKELEY TECH. L.J. 331, 334 (2007).

¹²⁵ *Id.* at 332.

¹²⁶ "Transformative" joined the lexicon of fair use decision-making in *Campbell v. Acuff-Rose-Music, Inc.*, 510 U.S. 569, 579 (1994), and means a use that "adds something new, with a further purpose or different character" so as to

appropriation an infringement, fair use furthers Lessig's "Progress Clause" by placing the economic benefits copyright confers upon creators beneath the primary Constitutional goal of maximizing dissemination of new works for the greater benefit of the general public.¹²⁷

Fair use is part of a web of doctrines which restrains copyright's monopolistic tendencies: the limited term of exclusive rights encoded in the first Copyright Act; the idea-expression distinction, which denies protection to an idea, and only confers copyright on the expression of that idea;¹²⁸ the refusal to recognize facts as falling under the subject matter of copyright;¹²⁹ and the "first sale" doctrine, which "exhausts" an owner's right of distribution by permitting the sale of used books or the rental of DVDs after the initial lawful purchase.¹³⁰ The Supreme Court has stated that these limiting doctrines, some of which have their origins at common law, are not "unforeseen byproduct[s] of a statutory scheme," but instead balances authors' "right to their original expression, but encourages others to build free[ly] upon ... [their earlier] work."¹³¹

Though the doctrine of fair use appeared in English law before our own copyright regime was in place,¹³² it was not integrated into U.S.

alter an original work "with new expression, meaning or message." As shall be seen, it has often been viewed as dispositive in fair use cases.

¹²⁷ See Forkner, *supra* note 6, at 720-21 and LESSIG, *supra* note 3, at 130-31.

¹²⁸ Lee Ann W. Lockridge, *The Myth of Copyright's Fair Use Doctrine as a Protector of Free Speech*, 24 SANTA CLARA COMPUTER & HIGH TECH L.J. 31, 36-37 (2007) (citing 17 U.S.C. § 102(b)).

¹²⁹ *Id.* at 36 (citing *Feist Publ'ns v. Rural Tel. Serv. Co.*, 499 U.S. 340, 344 (1991)).

¹³⁰ WILLIAM F. PATRY, COPYRIGHT LAW AND PRACTICE 842-43 (1994).

¹³¹ See *Feist Publ'ns v. Rural Tel. Serv. Co.*, 499 U.S. 340, 349-50 (1991) (quoted in Fair Use: Its Effects on Consumers and Industry: Hearing Before the Subcomm. on Commerce, Trade and Consumer Protection of the H. Comm. on Energy and Commerce, 109th Cong. (2005) (testimony of Peter Jaszi, Professor, American University Washington College of Law)).

¹³² Lydia Pallas Loren, *Redefining the Market Failure Approach to Fair Use in an Era of Copyright Permission Systems*, 5 J. INTELL. PROP. L. 1, 15 (1997).

common law until Justice Story's 1841 opinion in *Folsom v. Marsh*¹³³. In *Folsom*, Justice Story outlined several factors courts should weigh in deciding whether or not a use was fair: "look to the nature and objects of the selections made, the quantity and value of materials used, and the degree in which the use may prejudice the sale, or diminish the profits, or supersede the objects, of the original work."¹³⁴

Justice Story's common law enunciation of fair use was followed for 135 years before the factors were finally codified in the Copyright Act of 1976:

[The] fair use of a copyrighted work . . . for purposes such as criticism, comment, news reporting, teaching . . . , scholarship, or research, is not an infringement of copyright. In determining whether the use made of a work in any particular case is a fair use the factors to be considered shall include –

- (1) The purpose and character of the use, including whether such use is of a commercial nature or is for non-profit educational purposes;
- (2) The nature of the copyrighted work;
- (3) The amount and substantiality of the portion used in relation to the copyrighted work as a whole.
- (4) The effect of the use upon the potential market or value of the copyrighted work.¹³⁵

Fair use may be seen as a "enforced consent" imposed upon the original author, who, in return for statutory protection of her exclusive rights, is deemed to assent to reasonable uses of her work. Thus, fair use and consequently "enforced consent" satisfy the Constitutional aim of promoting expansion of the public fund of knowledge; if second uses also further the promotion of the public good.¹³⁶

¹³³ 9 F. Cas. 342 (C.C.D. Mass. 1841) (No. 4,901).

¹³⁴ *Id.* at 348.

¹³⁵ Copyright Act of 1976, 17 U.S.C. § 107 (2006).

¹³⁶ See generally Peter Jaszi, *Copyright, Fair Use and Motion Pictures*, 2007 UTAH L. REV. 715, 719 (2007) (citing ALAN LATMAN, STUDY NO. 14, FAIR USE OF COPYRIGHTED WORKS (1958), *reprinted in* 2 STUDIES ON COPYRIGHT 781, 785

Between 1909 and 1976, legislative extensions of a copyright's scope, subject matter, and corresponding penalties were paralleled by an increase in the number of infringement actions.¹³⁷ This was due in part, to the growth of both reproductive technology (the capacity to copy) and the power of mass media. These changes threatened to stifle new works by shrinking the public domain.¹³⁸ Courts in turn responded by embracing fair use.¹³⁹ It is possible that Congress decided to codify fair use in order to counteract the effects of its own expansion of copyright protection for the benefit of a burgeoning content industry.¹⁴⁰ The doctrine's codification in the 1976 Copyright Act kept copyright constitutional by limiting authors' exclusive rights. Unchecked, these exclusive rights would thwart the very progress in arts, sciences, and knowledge that copyright was created to promote.¹⁴¹

Congress acknowledged the role courts played in shaping the boundaries of copyright by incorporating the four factors originally outlined in *Folsom*, while allowing for continued refinement of the doctrine on a case-by-case basis.¹⁴² The House Report stated that the purpose of section 107 was to "restate the present judicial doctrine of fair use, not to change, narrow, or enlarge it in any way"¹⁴³. . . [S]ince the doctrine is an

(Arthur Fisher Memorial ed. 1963)).

¹³⁷ See generally Loren, *supra* note 132, at 18-21.

¹³⁸ *Id.* at 718.

¹³⁹ Pat Aufderheide, *How Documentary Filmmakers Overcame Their Fear of Quoting and Learned to Employ Fair Use: A Tale of Scholarship in Action*, 1 INT'L J. OF COMM. 26, 27 (2007); Paul Goldstein, *Fair Use in a Changing World*, 50 J. COPYRIGHT SOC'Y U.S.A 133, 136 (2003).

¹⁴⁰ See generally Loren, *supra* note 132, at 19.

¹⁴¹ *Id.* at 21.

¹⁴² Liu, *supra* note 15, at 99-100.

¹⁴³ While Congress stated that it intended no alteration in the common-law doctrine, the language dictating consideration of whether a use was for a commercial or non-profit educational purpose appeared very late in the drafting as a result of lobbying by educators, and did in fact constitute a contraction of the fair use doctrine which has since proven vexatious for documentary film-makers,

equitable rule of reason, no generally applicable definition is possible, and each case raising the question must be decided on its own facts.”¹⁴⁴

As a practical matter, fair use is an affirmative defense to infringement, and not a right, “a shield and not a sword.”¹⁴⁵ From a documentary film-makers standpoint, this poses a problem; the doctrine may only be utilized after one is sued for infringement.¹⁴⁶ Therefore, a film-maker has to endure the risk, having appropriated elements of a copyrighted work, either because the licensing fee was beyond her means, or else because the owner denied the license outright for brand-control or ideological reasons, of being subsequently sued rather than receiving a preemptive determination.¹⁴⁷ Even assuming the cost of litigation presents no obstacle to a film-maker (a considerable leap of faith, since the cost of defending an infringement action can range from \$290,000 to \$1 million, a cost far in excess of the unaffordable license¹⁴⁸), applying the mandatory four factors as an *ex ante* predictive exercise does not provide much guidance in determining whether the defense will be successful.¹⁴⁹

Most documentaries qualify as “criticism, comment, news reporting, teaching . . . , scholarship, or research.”¹⁵⁰ While, by this

among other potential users. See Lockridge, *supra* note 128, at 72-75; see also JESSICA LITMAN, DIGITAL COPYRIGHT 68-69 (2001).

¹⁴⁴ Maxton-Graham v. Burtchaell, 803 F.2d 1253,1260 (2d Cir. 1986).

¹⁴⁵ MICHAEL C. DONALDSON, *supra* note 118, at 280. “‘Fair use’ is not infringement of a copyright.” Michael J. Madison, *A Pattern-Oriented Approach to Fair Use*, 45 WM. & MARY L. REV. 1525, 1552 (2003). The most plausible reading of 17 U.S.C. § 107 would place the burden of proof on the plaintiff, but courts have put the burden on the defendant. *Id.* There is debate as well as to whether fair use constitutes a right or merely a privilege. *Id.*

¹⁴⁶ DONALDSON, *supra* note 118, at 280.

¹⁴⁷ See generally Madison, *supra* note 145, at 1569.

¹⁴⁸ Jennifer E. Rothman, *The Questionable Use of Custom in Intellectual Property*, 93 VA. L. REV. 1899, 1909 n.23 (2007) (citing American Intellectual Property Law Association, Report of the Economic Survey 2007, at 25 (2007)).

¹⁴⁹ *Id.* at 1910-11.

¹⁵⁰ *Id.* at 1910 n.27.

definition, fair use should be applicable to documentary films, they may also be considered commercial.¹⁵¹ Under the _____, whether the documentary is of a “commercial nature” impacts fair use analysis and may result in the first factor being found in favor of the owner. Many, documentaries have distribution deals with Hollywood studios, cable networks, and DVD producers. These deals create an aura of commercial exploitation that hovers over even the most high-minded nonfiction film.¹⁵² Also, the amount of material utilized from the copyrighted work impacts analysis under the third factor of the fair use test. Factor three asks “how much is too much,” and raises dual questions of “how much and how crucial was what was taken relative to the original work,” and “how much of the second work did it comprise.”¹⁵³ Even if the first three factors of the test can be satisfied, the fourth factor pre-supposes a licensing market for the copyrighted work which may render *any* abrogation of permission harmful, and thus not a fair use.

Since the four factor test offers little in the way of a determinative outcome one may want to consider fair use case-law. The case-law, however, also is indeterminative. Fair use is an equitable doctrine and as such cases were decided on a fact-intensive inquiry. Courts, following the express dictate of the Supreme Court, have refused to offer bright-line rules when interpreting Section 107. This has resulted not in doctrinal coherence but fragmentation.¹⁵⁴ This patchwork judicial application of the fair use test has led one of the foremost copyright scholars to label fair use “a fairy tale,” and to conclude, after surveying nearly a decades worth of fair use decisions, that “had Congress legislated a dartboard rather than [the factors in Section 107] . . . the upshot would be the same.”¹⁵⁵

¹⁵¹ This reflects an opinion by the author.

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ Madison, *supra* note 145, at 1570.

¹⁵⁵ David Nimmer, “*Fairest of Them All*” and *Other Fairy Tales of Fair Use*, 66 LAW & CONTEMP. PROBS. 263, 263, 280 (2003).

B. THE FOUR FAIR USE FACTORS IN THE SUPREME COURT

The Supreme Court, echoing the legislative history of Section 107, has stated that courts, faced with weighing the four fair use factors, are to avoid bright-line rule-making and tailor their analysis to each specific fact-pattern. In addition, no one factor of the four is determinative, and all are to be explored individually and weighed together.¹⁵⁶ As a consequence of this avowedly ad hoc nature of fair use decision-making, the doctrinal jurisprudence has been entirely judge-made, and is thus unpredictable.¹⁵⁷ As an example, two of the three Supreme Court fair use rulings were closely decided, and all three involved reversals first in the federal appellate courts and then again at the Supreme Court.¹⁵⁸

These three Supreme Court fair use decisions staked out certain doctrinal refinements subsequently employed by lower courts. These refinements, however, are not firm guidelines for documentary filmmakers. Rather, they are more like variables in an ex ante calculus regarding whether to gamble on incurring an infringement suit resulting from a fair use.¹⁵⁹

Universal City Studios v. Sony was a challenge by the motion picture industry's to the video cassette recorder, then in its infancy. The studios claimed private home-taping of copyrighted television programming for later viewing constituted infringement.¹⁶⁰ The court found that such private non-commercial use was fair, but noted that under the statutory fair use factor, "purpose and character of the use," a commercial or profit-making private use would be presumptively unfair.¹⁶¹ Consideration of the commercial purpose of the use does comport with the language of the statute, but risks tilting every decision towards the copyright holder and away from fair use, especially when weighed in light

¹⁵⁶ *Campbell v. Acuff-Rose Music, Inc.*, 510 U.S. 569, 578 (1994).

¹⁵⁷ *Madison*, *supra* note 145, at 1666.

¹⁵⁸ *Id.* at 1666.

¹⁵⁹ *See Madison*, *supra* note 145, at 1666.

¹⁶⁰ 464 U.S. 417 (1984).

¹⁶¹ *Id.* at 451.

of the fourth factor, the effect of the use on the marketplace for the copyrighted work.¹⁶²

In *Harper & Row Publishers, Inc. v. Nation Enterprises*, a progressive news magazine “scooped” the forthcoming publication of Gerald Ford’s memoirs and an authorized excerpt due to run in *Time* magazine, when it received a pilfered manuscript and published the most sensational portion, Ford’s account of his pardon of President Nixon.¹⁶³

The Court reaffirmed that commercial use is presumptively unfair, stating that the user’s profit motive alone was not at issue, but whether “the user stands to profit from exploitation of the copyrighted material without paying the customary price.”¹⁶⁴ In addressing the third factor, “the amount and substantiality of the portion used in relation to the copyrighted work as a whole,” where *The Nation* had only copied a very small part of Ford’s book and had surrounded it with a substantial amount of original reportage, the Court applied a qualitative, rather than quantitative analysis, and found the use unfair because “the heart of the work” had been copied.¹⁶⁵

Most significantly, the Court termed the fourth factor “undoubtedly the single most important element of fair use.”¹⁶⁶ Due to the fact that *Time* cancelled serialization subsequent to *The Nation*’s scoop, and the book publisher’s consequent monetary loss was found to be conclusive proof of actual market harm, the Court shifted the burden of proof to the defendant for rebuttal. *The Nation* failed to do so, and the Court found no fair use.¹⁶⁷

The most recent case in the Supreme Court’s fair use trilogy, *Campbell v. Acuff-Rose Music, Inc.*, has proven to be the most significant in terms of providing a fair use guideline to the lower courts.¹⁶⁸ Here, rap group 2 Live Crew, had copied Roy Orbison’s wholesome early ‘60’s

¹⁶² *Id.* at 450-51.

¹⁶³ 471 U.S. 539, 542 (1985).

¹⁶⁴ *Id.* at 562.

¹⁶⁵ *Id.* at 564-66.

¹⁶⁶ *Id.* at 566.

¹⁶⁷ *Id.* at 567.

¹⁶⁸ 510 U.S. 569 (1994).

country-rock classic “Oh, Pretty Woman” for their gamier parody song “Pretty Woman.”¹⁶⁹

In contrast to *Sony Pictures* and *Harper and Row*, the Court held that the commercial nature of the use was not dispositive, but merely one factor to be weighed among the four.¹⁷⁰ The Court recognized that the enumerated fair uses in the statute – news reporting, criticism, commentary, etc. – are invariably paid for by *someone*, quoting Dr. Johnson’s “No man but a blockhead ever wrote, except for money.”¹⁷¹ In shifting its attention away from whether the use was a commercial exploitation of a copyrighted work, the Court introduced a new criteria for the first factor’s “purpose and character of the use” which seemed to take fair use back to its origins in the social bargain of the Copyright Clause: was the secondary work “transformative?”¹⁷² That is, did the new work, in copying an older work, supersede or supplant the older work in the marketplace, or did it :

add something new, with a further purpose or different character, altering the first with new expression, meaning, or messagesuch works . . . lie at the heart of the fair use doctrine’s breathing space within the confines of copyright, and the more transformative the new work, the less will be the significance of the other factors, like commercialism, that may weigh against finding fair use.¹⁷³

¹⁶⁹ *Id.* at 572. In addition, the Court carved out a parody exception to an author’s exclusive rights, holding that since a parody is by nature a derivative work, remand was necessary for further inquiry under the fourth fair use factor as to whether the rap song had incurred any harm to the owner’s potential market for its own derivative rap-parody work. *Id.* at 592-93.

¹⁷⁰ *Id.* at 584-85.

¹⁷¹ *Id.* at 584.

¹⁷² *Id.* at 578-79.

¹⁷³ *Campbell v. Acuff-Rose Music, Inc.*, 510 U.S. 569, 579 (1994). The Court found that the raunchy rap version of “Oh, Pretty Woman” was a parody, and hence transformative. The Court reasoned that for a parody to succeed, it must, by definition, take enough from the original to elicit the minimum degree of recognition for the joke to properly effect the audience. Moreover, the Court found that the subjects of parody will often be unlikely to want to see themselves

Since *Campbell*, the transformative inquiry has been central to fair use decision-making, despite the fact that the phrase appears nowhere in the statute.¹⁷⁴ In every case in the appellate courts since then, if the court found the use to be transformative, it was fair use; if the use was found not to be transformative, it was infringing.¹⁷⁵ The relevance of the inquiry to the documentary context is self-evident, in that a court could arguably find that with any given use, a documentarian, by arranging the copyrighted materials used within a novel context, had transformed it. However, a finding of transformativeness is necessarily going to be a result-oriented inquiry; just about any use that is not mere plagiaristic replication transforms the original in some way, and defining the point where copying as pure commercial exploitation ends and transformation begins is so dependent upon judicial discretion that a potential defendant is in no position to guess before she copies.¹⁷⁶

Copyright scholar David Nimmer views the malleability of the four fair use factors as enabling results-oriented, and hence subjective and imprecise, fair-use decision-making: “At best the four factors fail to drive the analysis, but rather serve as convenient pegs on which to hang antecedent conclusions.”¹⁷⁷

The tension between two of the factors, which can subsume the others, is the reason. On the one hand, the purpose and character of the use leads the court to examine whether the use of an older work has transformed that material into a novel one. The fourth factor, inquiring as to how the use has affected a potential market for the original work leads courts to examine whether even the very existence of an actual or potential licensing market has been harmed by the use. But by using harm to a *potential* market as a bar to fair use, courts invite circular reasoning; in this era of rapid technological change in media dissemination, cross-licensing arrangements, and lengthened copyright terms, it is a simple matter for a

parodied, and may deny a license for that reason alone, making fair use an appropriate defense to infringement when a parody is at issue.

¹⁷⁴ DONALDSON, *supra* note 118, at 288.

¹⁷⁵ Forkner, *supra* note 6, at 745.

¹⁷⁶ Madison, *supra* note 12, at 1558-59.

¹⁷⁷ Nimmer, *supra* note 155, at 281.

copyright owner to define its own potential market and thus claim injury, and sweep away the transformative inquiry altogether.¹⁷⁸

This tension has played itself out in a circuit split. Federal courts in New York, taking their cue from *Campbell*, have held that the first factor, under the transformative inquiry, is the most important.¹⁷⁹ But most federal courts in California have followed *Harper & Row* in taking the position that the fourth factor, harm to the licensing market, is the most important factor.¹⁸⁰ As a consequence of this uncertainty, one prominent copyright attorney advising film-makers considering using copyrighted material, has stated “you should always err in favor of asking and paying.”¹⁸¹ Thus, to avoid the appearance of market harm, one documentarian feels compelled to pay thousands of dollars to use a ring-tone despite undoubted aesthetic transformation when the sound inhibits a little boy from telling his mom about his school day in *Mad Hot Ballroom*; while the makers of *Hoop Dreams* similarly feels obliged to pay the owners of “Happy Birthday” when the song occurs in the transformative context of an 18th birthday party in the Chicago housing projects, and elicits the mother’s poignant comment that her son is lucky to have reached 18.¹⁸²

C. FAIR USE AND NON-FICTION FILMS IN THE COURTS

Since the Supreme Court birthed the transformative criteria in *Campbell*, there have been eight significant fair use decisions relevant to non-fiction film and its close cousin, television news reporting.¹⁸³ All were

¹⁷⁸ See generally Marques, *supra* note 124, at 340-41.

¹⁷⁹ See *Blanch v. Koons*, 467 F.3d 244 (2nd Cir. 2006); *NXIVM Corp. v. Ross Inst.*, 364 F.3d 471 (2nd Cir. 2004); *On Davis v. The Gap, Inc.*, 246 F.3d 152 (2nd Cir. 2001); *Castle Rock Entm’t, Inc. v. Carol Pub. Group, Inc.*, 150 F.3d 132 (2nd Cir. 1998); *Leibovitz v. Paramount Pictures Corp.*, 137 F.3d 109 (2nd Cir. 1998); *Ringgold v. Black Entm’t Television, Inc.*, 126 F.3d 70 (2nd Cir. 1997).

¹⁸⁰ DONALDSON, *supra* note 118, at 282.

¹⁸¹ *Id.*

¹⁸² Forkner, *supra* note 6, at 744.

¹⁸³ See *Elvis Presley Enter., Inc. v. Passport Video*, 349 F.3d 622 (9th Cir. 2003); *Los Angeles News Serv. v. CBS Broad., Inc.*, 305 F.3d 924 (9th Cir. 2002);

decided in either New York or Los Angeles, which is not surprising, as the Second and Ninth Circuits are the twin domiciles to the U.S. media industries. Two salient points emerged from the cases: on the one hand, they express the tension between the application of the first, transformative factor, favoring users, and the fourth “effect on the potential market” factor, favoring copyright owners. Second, the cases relating to nonfiction film at least superficially demonstrates the ad hoc uncertainty which is the consequence of the kind of case-by-case analysis called for by Congress and the Court.

i. *The California Cases: The King and Chopper Bob*

In *Elvis Presley Enterprises, Inc. v. Passport Video*,¹⁸⁴ the defendant, producers of a 16 hour video biography of the King of Rock and Roll created for retail sale, sought to lift an injunction against their documentary won in the District Court by the plaintiffs, amongst whom were the rights-holders of Elvis Presley’s television Performances.¹⁸⁵ The advertising copy on the box touted the fact that the film included footage from every film and television appearance of Elvis.¹⁸⁶ The copyrighted materials provoking the infringement action constituted five to ten percent of its sixteen hour length;¹⁸⁷ the materials include all of his appearances on the Steven Allen show, 35% of Elvis’ career-making Ed Sullivan appearances, and three minutes of his epochal 1968 comeback TV special.¹⁸⁸ The film-makers

Hofheinz v. AMC Prod.’s, Inc., 147 F. Supp.2d 127 (S.D. N.Y. 2001); Hofheinz v. A & E Television Networks, 146 F.Supp.2d 442 (S.D. N.Y. 2001); Hofheinz v. Discovery Commc’ns, Inc., No. 00 CIV. 3802 (HB), 2001 WL 1111970 (S.D. N.Y. Sept. 20, 2001); Los Angeles News Serv. v. Reuters Television Int’l, Ltd., 149 F.3d 987 (9th Cir. 1998); Los Angeles News Serv. v. KCAL-TV Channel 9, 108 F.3d 1119 (9th Cir. 1997); Monster Commc’ns Inc., v. Turner Broad. Sys., Inc. 935 F. Supp. 490 (S.D. N.Y. 1996).

¹⁸⁴ 349 F.3d 622 (9th Cir. 2003).

¹⁸⁵ *Id.* at 626.

¹⁸⁶ *Id.* at 625.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

asserted fair use, and the Ninth Circuit,¹⁸⁹ after weighing the four factors, affirmed the injunction sought by the plaintiffs.¹⁹⁰

The court performed the four-factor analysis and found no fair use.¹⁹¹ First, looking to the purpose and character of the use, the court cited *Harper & Row's* proposition that a commercial use disfavors a defendant to the degree to which the user exploits the copyrighted material for commercial gain.¹⁹² Specifically, the Ninth Circuit concluded that the use was “not consistently transformative,” and that the presence of the voice-over commentary was insufficient for any mitigation;¹⁹³ the court indicated the long length of some clips amounted to essentially a re-broadcast of the copyrighted materials rather than use as reference to Presley’s career.¹⁹⁴ Moreover, the court believed that the commercial nature and purpose outweighed any transformation because the advertising touting the fact the video includes every television appearance indicates their inherent desire to profit from the copyrighted materials.¹⁹⁵

The second factor, the nature of the copyrighted work, was found to be neutral, as the clips were both newsworthy, hence less protected and creative expression, which enjoys more protection.¹⁹⁶ For the third factor, amount and substantiality of the use, the court found that the film-makers

¹⁸⁹ *Id.* at 626.

¹⁹⁰ *Elvis Presley*, 349 F.3d at 631 (The court noted in reviewing an injunction, an abuse of discretion standard controlled, and that it believed the case was closer than the district court had held; had these facts come before the appellate court under de novo review, the court acknowledged the outcome may have been different). *Id.*

¹⁹¹ *Id.* at 627-31.

¹⁹² *Id.* at 627.

¹⁹³ *Id.* at 628-29 (citing *Monster Commc’ns, Inc. v. Turner Broad. Sys., Inc.*, 935 F. Supp. 490 (S.D.N.Y. 1996) and *Hofheinz v. A&E Television, Inc.*, 146 F. Supp. 2d 442 (S.D.N.Y. 2001)).

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Elvis Presley*, 349 F.3d at 629-30.

had taken the heart of the work¹⁹⁷ by copying the material that would likely be licensed, the most memorable parts of Elvis' hits.¹⁹⁸ Finally, the court identified the fourth factor, the effect on the potential market, as "the single most important of all the factors."¹⁹⁹ The court found no fair use, stating that if others similarly used the plaintiff's footage without paying for it, the plaintiff's market for licensing works would be undermined. Effectively, the clips would be used for the same purpose as the plaintiff's original work.²⁰⁰

Overall, in *Presley* the Ninth's Circuits Section 107 analysis focused on the harm to the plaintiff's potential market. The court seemingly dismissed any transformation of the clips when viewed in light of the film's biographical re-contextualization under the vague standard of "inconsistency."²⁰¹ The result was a documentarian's fair use worst-case scenario: the death of a film, which had cost \$2 million and years to produce, by means of a permanent injunction.²⁰²

¹⁹⁷ *Id.* at 630-31.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.* at 630-31.

²⁰⁰ *Id.* at 631.

²⁰¹ *Elvis Presley*, 349 F.3d at 628-29.

²⁰² Paige Gold, *Fair Use and the First Amendment: Corporate Control of Copyright is Stifling Documentary-Making and Thwarting the Aims of the First Amendment*, 15 U. BALT. INTEL. PROP. L.J. 28, 29 (2006). Judge Noonan, the dissenting judge in *Presley*, was so disturbed by what he termed the court's embrace of the trial court's factual and legal errors, particularly with respect to the transformative fair use analysis and the protection of the public's interest in copyright's social bargain, that three months later he amended his dissent to broaden his argument to incorporate constitutional questions. See *Elvis Presley*, 349 F.3d at 631-34 ((Noonan, J., dissenting), amended by 357 F.3d 896 (9th Cir. 2004)). The decision is indicative of the instability of judicial analysis of the four factors, because if the district court had weighed them as Judge Noonan suggested, and as courts in New York did in *A&E* and *Monster Communications*, a fair use finding may have resulted. See generally Krissi Geary, *Video Biography Gets All Shook Up: Elvis Presley Enterprises, Inc. v. Passport Video*, 29 S. ILL. U. L.J. 151, 161-64 (2004).

The Ninth Circuit's subsequent fair use decisions clouded rather than clarified doctrinal boundaries. There were three cases involving the same plaintiff, the Los Angeles News Service ("LANS") suing for the use of the same film footage.²⁰³ While in all three cases the court gave substantial weight to the fourth "market effect factor" unlike in *Presley*, transformative fair use was found in one.²⁰⁴

Robert Tur, owner of LANS and free-lance helicopter news cameraman,²⁰⁵ flew his helicopter to the flashpoint of a riot that occurred after the 1992 verdict acquitting the police officers who had beaten Rodney King.²⁰⁶ Tur managed to film nine minutes of footage of Reginald Denny being pulled from his car and beaten nearly to death by gang members. Tur scooped all of the local national news outlets and insisted that they do not use the footage without a license.²⁰⁷

LANS had two victories in fair use defense cases against the Los Angeles News station K-CAL and international news service Reuters.²⁰⁸ Both defending parties did not manage to obtain a license and thus tried to

²⁰³ *L.A. News Serv. v. CBS Broad., Inc.*, 305 F.3d 924, 929 (9th Cir. 2002); *L.A. News Serv. v. Reuters Television Int'l, Ltd.*, 149 F.3d 987, 990 (9th Cir. 1998); *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d 1119, 1120 (9th Cir. 1997).

²⁰⁴ *L.A. News Serv. v. CBS Broad., Inc.*, 305 F.3d at 940.

²⁰⁵ Matthew Belloni, *The Man Who Could Kill YouTube*, *ESQUIRE*, July 2007, at 71.

²⁰⁶ *Id.*

²⁰⁷ *Id.* at 71-72. 17 years later, Tur is still litigating unauthorized use of the footage, this time against YouTube, whom he vows to shut down. *Id.* He has since moved to join his action with numerous corporate media plaintiff's pursuing similar claims. See *Tur v. YouTube*, No. CV-4436, 2007 U.S. Dist. LEXIS 96517, at *2 (C.D. Cal. Oct. 19, 2007).

²⁰⁸ *L.A. News Serv., v. Reuters Television Int'l Ltd.*, 149 F.3d at 997; *L.A. News Serv. v. K-CAL-TV Channel 9*, 108 F.3d at 1123.

justify their use of LANS footage through the doctrine of fair use.²⁰⁹ The Ninth Circuit found that in both cases, the defendant's use was not fair.²¹⁰

With respect to the first factor, the commercial nature and purpose of the use, the court found no fair use because LANS and the defendants were competitors; this negated the fact that the clips were used for news, one of the factors enumerated in Section 107.²¹¹ Furthermore, the court concluded that transformativeness of the material was absent because the voice-over failed to fundamentally change the nature of the video recording.²¹²

Regarding the second factor, the nature of the copyrighted work, the court favored both defendants because the copyrighted work was factual rather than expressive.²¹³ Next, the court found that in both cases the amount and substantiality of the use amounted to the heart of the work because the images of the beating was exactly what legitimate licensees would want the clip for.²¹⁴ Finally, the court looked at the effect on the plaintiff's market and concluded both that the commercial use was presumptively unfair, and using clips that would normally be licensed would destroy the plaintiff's market.²¹⁵

²⁰⁹ *L.A. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 994; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1123.

²¹⁰ *L.A. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 997; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1123.

²¹¹ *LA. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 994; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1123.

²¹² *L.A. News Serv. v. KCA-TV Channel 9*, 108 F.3d at 1122-23. In *Reuters*, the court also found with respect to the first factor that the defendant could not claim a fair use exemption for news, since a new service does not report news but merely collects and transmits it for others to broadcast. 149 F.3d at 994.

²¹³ *L.A. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 994; *L.A. News Serv. v. K-CAL-TV Channel 9*, 108 F.3d at 1122.

²¹⁴ *LA. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 994; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1122.

²¹⁵ *LA. News Serv. v. Reuters Television Int'l Ltd.*, 149 F.3d at 994; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1123.

The Ninth Circuit took a different position in the *Los Angeles New Service v. CBS Broadcasting, Inc.*, concluding that there was transformativeness of the material and thus the defendant could assert the fair use defense.²¹⁶ In this case, the cable network Court TV used brief images of the Denny beating in advertising “teasers” to promote its coverage of the trial of Denny’s assailants and in the opening title montage for the show “Prime Time Justice.”²¹⁷

Regarding the first factor, the purpose and character of the use, the court found that both instances were commercial in nature because of its promotion of the network’s trial coverage.²¹⁸ The Ninth circuit reasoned that though an advertising “teaser” was not transformative per se, this was mitigated by the fact that, as opposed to Reuters and K-CAL, Court TV was not a direct competitor of LANS.²¹⁹ Furthermore, the court reasoned that the use of footage in the title montage was sufficiently transformative because of the creative use of graphics beyond a mere copying of the clip.²²⁰ On balance, the court found the first factor “weakly” favored fair use.²²¹

The nature of the copyrighted work, here as in the other two LANS cases, tilted towards fair use since there were factual materials at issue.²²² Regarding the third factor, the amount and substantiality of the use, LANS’ prior fair uses cases came back to haunt the court.²²³ The court explained that unlike in *Reuters*, where it was argued that the 45 second clip constituted the heart of the work, only a few seconds were used by Court

²¹⁶ *L.A. News Serv. v. CBS Broadcasting, Inc.*, 305 F.3d at 942.

²¹⁷ *Id.* at 929.

²¹⁸ *Id.* at 939-40.

²¹⁹ *Id.* at 940.

²²⁰ *Id.* at 939.

²²¹ *Id.* at 940.

²²² *L.A. News Serv. v. CBS Broadcasting, Inc.*, 305 F.3d at 940.

²²³ *Id.*

TV and thus did not qualify as the “heart” of the work.²²⁴ Finally, the Ninth Circuit concluded that the defendant did not adversely affect LANS potential market for two reasons.²²⁵ First, they explained that the clip montage was unlikely to affect the plaintiff’s market because it was transformative,²²⁶ and the lack of competition between LANS and Court TV mitigated the concern of the teaser footage not being transformative.²²⁷

The Tur trio reveals the importance of the transformative test, especially with regard to an owner-friendly court like the Ninth Circuit. In *K-CAL* and *Reuters*, where the character and purpose of the use was news reporting, an enumerated fair use exception in Section 107, fair use was denied; yet in *CBS*, where the use was purely commercial, the court found transformative fair use.²²⁸

ii. *The New York Cases: The Greatest and The Shlockmeister’s Widow*

While the Ninth Circuit advanced *Harper & Row’s* presumption that commercial uses are unfair, and advanced the fourth “market harm” factor as determinative, the district courts in New York City emphasized the transformative test from *Campbell* in their fair use decision making.²²⁹

²²⁴ *Id.* at 940-41.

²²⁵ *Id.* at 941-42.

²²⁶ *Id.* at 941.

²²⁷ *Id.* at 942.

²²⁸ *L.A. News Serv. v. CBS Broad., Inc.*, 305 F.3d at 942); *L.A. News Serv. v. Reuters Television Int’l, Ltd.*, 149 F.3d at 997; *L.A. News Serv. v. KCAL-TV Channel 9*, 108 F.3d at 1123).

²²⁹ *Hofheinz v. Discovery Commc’n, Inc.*, No. 00 Civ. 3802, 2001 U.S. Dist. LEXIS 14752, at *10 n.6 (S.D.N.Y. 2001). This judicial favoring of the transformative test was ultimately embraced by the Second Circuit in two decisions handed down in 2006. *Bill Graham Archives.*, 448 F.3d at 608; *Blanch v. Koons*, 467 F.3d at 250. While neither of these decisions occurred within the non-fiction film context, commentators and copyright attorneys have recognized their potential positive significance for documentarians asserting a fair use defense. In *Graham* and *Blanch*, the court allowed the transformative inquiry to dominate all other considerations. In both cases, minimal aesthetic changes to the copyrighted work

In *Monster Communications, Inc. v. Turner Broadcasting System*, the plaintiffs were the producers of the documentary “When We Were Kings” which told the story of Muhammad Ali’s 1974 fight in Zaire.²³⁰ The defendants, producers of a cable documentary “Ali-The Whole Story” used between 41 seconds and 2 minutes of the plaintiff’s footage without permission.²³¹ The plaintiff filed suit and the court found in favor of the defendant on the basis of fair use.²³²

The court concluded that the first factor, nature and character of the use, favored fair use because a biography fulfills many of the enumerated purposes set forth in Section 107.²³³ Specifically, the biography could qualify as a comment, criticism, or scholarship and research, and thus could be considered fair use regardless of the commercial nature of the film.²³⁴ Regarding the second factor, the nature of the copyrighted work, the court explained that despite the creativity present in the original work, “Kings,” a denial of fair use to a film depicting history would deprive the public of information.²³⁵ The court, however, determined that the second factor did not favor the defendant because the story could have been told without using the plaintiff’s clips.²³⁶

and the work’s contextualization within the expressive totality of the second work were sufficient for findings of transformativeness. And once transformativeness was found, market considerations were largely mooted. Perhaps more importantly for documentarians, the court expanded the statutory enumerated fair use purposes to include creative works, mandating looking to the expressive purpose of the use, and not merely the functional purpose. In the future, this may open the door for courts to make a prima facie finding for documentaries as legitimate fair users. See Marques, *supra* note 124, at 347-52.

²³⁰ *Monster Communications*, 935 F. Supp. at 491.

²³¹ *Id.*

²³² *Id.* at 496.

²³³ *Id.* at 494.

²³⁴ *Id.* at 493-94.

²³⁵ *Monster Communications*, 935 F. Supp. at 493-94.

²³⁶ *Id.* at 495.

With respect to the third factor, the amount and substantiality of the use, the court found in favor of fair use. The court reasoned that quantitatively the use was too small such that it was barely noticeable when viewing the two films in a back-to-back screening.²³⁷ Moreover, the portion of the defendant's film dealing with the 1974 Zaire fight occupied only nine minutes of the infringing work.²³⁸ On the fourth factor, the court concluded that there was too little use of the plaintiff's work to have any potentially adverse effect its licensing market.²³⁹

The New York decisions, like the Ninth Circuit, also involve a trilogy of cases brought by a single litigious copyright-holder.²⁴⁰ The cases involved documentarian and TV networks use of clips from films produced by American International Pictures ("AIP"). From the 1950s to the early 1970s, AIP was famous for creating science fiction and drive-in features. Susan Hofheinz, widow of AIP founder-principal James H. Nicholson, sued three separate film makers for using clips from AIP's films. The Southern District of New York found fair use in all three cases.

In *Hofheinz v. AMC Productions, Inc.*,²⁴¹ American Movie Classics was producing a documentary history of AIP with the cooperation of Ms. Hofheinz.²⁴² Hofheinz licensed six 59-second clips,²⁴³ but shortly before the film's theatrical screening, she withdrew her involvement and voided all licenses. Further, she warned AMC that any exhibition of the film segments would constitute infringement.²⁴⁴ AMC screened the film

²³⁷ *Id.* at 495.

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ See *Hofheinz v. AMC Prods., Inc.*, 147 F. Supp. 2d 127 (S.D.N.Y. 2001); *Hofheinz v. A & E Television Networks*, 146 F. Supp. 2d 442 (S.D.N.Y. 2001); *Hofheinz v. Discovery Commc'ns, Inc.*, No. 00 civ. 3802 (HB), 2001 U.S. Dist. LEXIS 14752 (S.D.N.Y. Sept. 20, 2001).

²⁴¹ 147 F. Supp. 2d 127 (S.D.N.Y. 2001).

²⁴² *Id.* at 130-31.

²⁴³ *Id.*

²⁴⁴ *Id.* at 133.

anyway and Hofheinz sued. In *Hofheinz v. A&E Television Networks*, a 20 second-clip from the AIP film “It Conquered the World”²⁴⁵ was used, without permission, in an episode of the cable series “Biography,” profiling actor Peter Graves.²⁴⁶ The clip illustrated Grave’s pre-stardom work in low-budget films.²⁴⁷ In the final AIP case, *Hofheinz v. Discovery Communications, Inc.*, the defendant cable network used the plaintiff’s clips in a multi-episode documentary of the history of the horror movie genre.²⁴⁸ One segment examined Hollywood’s representation of extraterrestrial visitations; three clips totaling 48 seconds in length, with voice –over on the soundtrack, were taken from AIP’s “Invasion of the Saucermen” without permission from Hofheinz.²⁴⁹

In examining the first factor, the purpose and character of the use, the district court found fair use in the Hofheinz trilogy.²⁵⁰ The court concluded that the plaintiffs had sufficiently transformed the clips, and there was a lower presumption against AMC’s commercial purpose because the copyrighted materials were not superseded by their incorporation in a wholly new work.²⁵¹ In *AMC* and *A & E*, the court explained that the use of the clips were per se transformative because as a biographical documentary it satisfied many of the enumerated purposes of

²⁴⁵ The clip was taken not from the AMC Documentary discussed above, but from the alien-invasion film from which it took its title. *IT CONQUERED THE WORLD* (American International Pictures 1956).

²⁴⁶ 146 F. Supp. 2d 442, 443-44 (S.D.N.Y. 2001).

²⁴⁷ *Id.* at 444.

²⁴⁸ *Hofheinz v. Discovery Commc’ns, Inc.*, No. 00 civ. 3802 (HB), 2001 U.S. Dist. LEXIS 14752, at *1 (S.D.N.Y. Sept. 20, 2001).

²⁴⁹ *Id.* at *5-7.

²⁵⁰ *A & E Television Networks*, 146 F. Supp. 2d at 446-47; *AMC Prods.*, 147 F. Supp. 2d 127, 137-38; *Discovery Commc’ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *17-*18.

²⁵¹ *A & E Television Networks*, 146 F. Supp. 2d at 446-47; *AMC Prods.*, 147 F. Supp. 2d at 137-38; *Discovery Commc’ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *17-18.

Section 107; namely being a criticism, comment, or research.²⁵² The *Discovery* case extended the transformative analysis beyond the parameters of biography. The court held that transformativeness “forms the basis for the entire fair use analysis” and not merely for the first factor inquiry.²⁵³ In *Discovery*, Hofheinz’s clips were used to establish that “Saucermen” was the first film to depict government efforts to cover up the existence of UFO’s. The clips fit into the film’s overall examination of common themes and political context of science fiction films. Thus the work was transformed.²⁵⁴

Finally, as in the Ninth Circuit’s *Presley* decision, Hofheinz argued that the clips taken by all three defendants were used solely for entertainment value, thus acting as competitors with each other and hurting the marketplace for AIP films.²⁵⁵ The district court explained that while the defendant’s films had entertainment value, they were also intended to educate the audience.²⁵⁶ Thus, since Section 107’s enumerated list of fair use purposes was non-exhaustive, entertainment value did not preclude a second user.²⁵⁷

In analyzing the second factor, the nature of the copyrighted work, the district court was definitive. In *AMC*, the court found this factor in favor of the plaintiff because the AIP films were creative works. In *A & E* and *Discovery*, however, the court did not find in favor of either party.

²⁵² *A & E Television Networks*, 146 F. Supp. 2d at 446; *AMC Prods.*, 147 F. Supp. 2d at 138.

²⁵³ *Discovery Commc’ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *10.

²⁵⁴ Hofheinz v. *Discovery Commc’ns, Inc.*, No. 00 civ. 3802 (HB), 2001 U.S. Dist. LEXIS 14752, at *12-15 (S.D.N.Y. Sept. 20, 2001).

²⁵⁵ *Id.* at *13; *A & E Television Networks*, 146 F. Supp. 2d at 447; *AMC Prods.*, 147 F. Supp. 2d at 138.

²⁵⁶ *Discovery Commc’ns*, 2001 U.S. Dist. LEXIS 14752, at *13; *A & E Television Networks* 146 F. Supp. 2d at 446-47; *AMC Prods.*, 147 F. Supp. 2d at 137.

²⁵⁷ Hofheinz v. *Discovery Commc’ns*, No. 00 civ. 3802 (HB), 2001 U.S. Dist. LEXIS 14752, at *13, 17 (S.D.N.Y. Sept. 20, 2001); Hofheinz v. *AMC Prods.*, 146 F. Supp. 2d 442, 446-47 (E.D.N.Y. 2001); Hofheinz v. *A & E Television Networks*, 147 F. Supp. 2d at 138.

This was based on the fact that Hofheinz had managed to keep the films out of circulation. Thus, the unavailability of the films, according to the court, justified the defendant's appropriation.²⁵⁸ Regarding the third factor, the amount and substantiality of the use, the court, in all three cases, found that the use of the clips were either brief or fragmentary in nature. The defendants had taken on only what was necessary for their purpose and had not appropriated the heart of the work.²⁵⁹

With respect to the fourth factor, the court, in all three cases, found the use too diminutive in when compared to the whole work. This proportion was too insubstantial to cause any adverse effect on the plaintiff's potential licensing market.²⁶⁰ The court opined, in all three cases, that the defendants' use of the clips from AIP movies might actually stimulate audience interest in these long-dormant films.²⁶¹ In contrast to the Ninth Circuit's *Presley* holding, the court in the Hofheinz trilogy dismissed the plaintiff's argument that a finding of fair use would diminish the value of her ability to license AIP clips in the future.²⁶² The court in *AMC* believed that this argument would eviscerate fair use because the whole point of fair use is to recognize circumstances where a third party is not required to obtain a license.²⁶³

²⁵⁸ *Discovery Commc'ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *18-20; *A & E Television Networks*, 146 F. Supp. 2d at 444-45, 447-48.

²⁵⁹ *A & E Television Networks*, 146 F. Supp. 2d at 448; *AMC Prods.*, 147 F. Supp. 2d at 139; *Discovery Commc'ns*, 2001 U.S. Dist. LEXIS 14752 at *20-21.

²⁶⁰ *A & E Television Networks*, 146 F. Supp. 2d at 449; *AMC Prods.*, 147 F. Supp. 2d at 140; *Discovery Commc'ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *21-23.

²⁶¹ *A & E Television Networks*, 146 F. Supp. 2d at 449; *AMC Prods.*, 147 F. Supp. 2d at 140; *Discovery Commc'ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *23.

²⁶² *AMC Prods.*, 146 F. Supp. 2d at 449; *A & E Television Networks*, 147 F. Supp. 2d at 140-41. *Discovery Commc'ns, Inc.*, 2001 U.S. Dist. LEXIS 14752, at *23.

²⁶³ *Hofheinz v. AMC Prods.*, 147 F. Supp. 2d 127, 140-41 (E.D.N.Y. 2001). This language was echoed in *Discovery Communications*. See 2001 U.S. Dist. LEXIS 14752 at *23.

iii. *Lessons for Film-makers From the Fair Use Cases*

The fair use decisions expressly dealing with nonfiction films and television news illustrate the unpredictability inherent in fair use law. Further, the decisions highlight courts' insufficient guidance regarding the applicability of fair use law to documentary films.²⁶⁴ When viewed at a high level of generality, similar fact patterns produce opposing or counterintuitive results. *Elvis Presley Enterprises v. Passport Video* found the use of clips within a biographical documentary not to be fair use,²⁶⁵ while *Hofheinz v. A&E Network* and *Monster Communications v. Turner Broadcasting System* strongly suggested, and *Hofheinz v. Discovery Communications* expressly stated, a presumption of transformativeness in the biographical film context.²⁶⁶

All of the courts, however, stated that nonfictional copyrighted material utilized in a documentary, is accorded less protection than expressive, creative works. This is contrasted with *Los Angeles News Service v. Reuters* and *Los Angeles News Service v. K-CAL*, where the use of hot news footage of extraordinary public interest was not found to be fair use,²⁶⁷ while use of the fanciful and creative films of AIP was found to be fair in the *Hofheinz* trilogy.²⁶⁸

In *Elvis Presley* the court found that the documentary's use of the copyrighted material, with respect to entertainment value, was a mere

²⁶⁴ See generally Donaldson, *supra* note 118 at 291.

²⁶⁵ *Elvis Presley Enter. v. Passport Video*, 349 F.3d 622, 628-31 (9th Cir. 2003).

²⁶⁶ See *Hofheinz v. A & E Television Networks*, 146 F. Supp. 2d at 446; *Monster Commc'ns, Inc. v. Turner Broad. Sys., Inc.*, 935 F. Supp. 490, 493-94 (S.D.N.Y. 1996); *Hofheinz v. Discovery Commc'ns* 2001 U.S. Dist. LEXIS 14752, at *11.

²⁶⁷ See *Los Angeles News Serv. v. Reuters Television Int'l, Ltd.*, 149 F.3d 987, 990, 997 (9th Cir. 1998); *Los Angeles News Serv. v. KCAL-TV*, 108 F.3d 1119, 1120, 1123 (9th Cir. 1997).

²⁶⁸ *Hofheinz v. A & E Television Networks*, 146 F. Supp. 2d. 442, 447-49 (S.D.N.Y. 2001); *Hofheinz v. AMC Prods.*, 147 F. Supp. 2d. 127, 141 (E.D.N.Y. 2001); *Hofheinz v. Discovery Commc'ns*, No. 00 civ. 3802 (HB), 2001 U.S. Dist. LEXIS 14752, at *17-19, *21, *24.

substitute for the owners purpose, but in the *Hofheinz* cases, the court dismissed the entertainment value inherent in the use as a consideration altogether.²⁶⁹ The ad copy touting the inclusion of copyrighted material in *Elvis Presley* tainted the use of that material as unfair, but the same court accorded the use of the Denny footage in Court TV's ads as fair – after the aforementioned LANS decisions where it had held use of the same footage as news was unfair!²⁷⁰

Lawrence Lessig has suggested that the fair use defense, despite its codification in the Copyright Act, effectively does not exist for documentarians, because the inconsistent outcomes from litigation has rendered the defense too uncertain to rely upon:

The rules of “fair use” are self-consciously not self-authenticating. The Supreme Court has repeatedly insisted that lower courts not develop simple, automatic rules. The effect is that fair use in practice becomes the right to hire a lawyer, in contexts in which the defense of fair use rights is effectively impossible . . . If a documentary filmmaker wants to include a clip from [the news] in her film, the standard procedure is to ask permission, regardless of the length, and regardless of [its] transformative nature . . . [If permission is denied] the film maker must therefore decide whether . . . the use of the clip is . . . “fair.” That inquiry is fundamentally uncertain . . . [and] the expense of error is . . . extraordinarily high. The reality for most [documentary] filmmakers is thus not a public domain . . . The reality is that while the law effectively secures to writers a broad and unquestioned freedom to quote without permission, it grants no such freedom to filmmakers.²⁷¹

²⁶⁹ Compare *Elvis Presley*, 349 F.3d at 628-29; with *Hofheinz*, 147 F. Supp.2d at 127.

²⁷⁰ *Id.*; *Los Angeles News Serv. v. CBS Broad., Inc.*, 305 F.3d 924, 939-40 (9th Cir. 2002).

²⁷¹ Lawrence Lessig, *Re-Crafting a Public Domain*, 18 YALE J.L. & HUMAN (SPECIAL ISSUE). 56, 60-61(2006).

Further, as motion picture copyright attorney Michael Donaldson writes, “court cases are supposed to give us some guidance about how to behave. About all you can draw from these cases is that courts want you to behave.”²⁷²

And yet behavior may be precisely the element that harmonizes these documentary fair use decisions. It is possible that the documentary fair use case-law is but a palimpsest beneath which an older and a far more useful inquiry lies hidden. An English copyright infringement case from 1802, pre-dating the seminal U.S. fair use case *Folsom v. Marsh*, may provide a clue.²⁷³ In *Cary v. Kearsley*, Lord Ellenborough framed the fair use inquiry in this fashion: “Was the matter so taken used fairly with that view [for the promotion of science and the benefit of the public], and without what I may term the *animus furandi* [in effect, an intent to pirate]?”²⁷⁴

The documentary cases, while purporting to weigh the four factors, may instead indicate a judicial inquiry into whether a second user’s work fits within a privileged category which benefits the public, or whether a fair use defense is merely a mask for piracy.²⁷⁵ Thus *K-CAL* and *Reuters* denied fair use because the defendant were free-riding on the plaintiff’s footage, rather than reporting news; and the video biographers in *Elvis Presley* made the key error of boasting in their ad copy of the copyrighted film and television appearances within.²⁷⁶ In all the other cases, graphics, voice-overs, context all worked not merely to indicate transformativeness, but also an intent on the defendant’s part to add to the domain of public knowledge.²⁷⁷ The courts deployed the four factor analysis to reassure

²⁷² DONALDSON, *supra* note 118, at 291.

²⁷³ 9 F. Cas. 342 (C.C.D. Mass. 1841).

²⁷⁴ 1802, 170 Eng. Rep. 679, 680 (K.B.).

²⁷⁵ See *supra* n. 264-68 and accompanying text.

²⁷⁶ *Los Angeles News Serv. v. KCAL-TV*, 108 F.3d at 1120, 1123; *Los Angeles News Serv. v. Reuters Television Int’l Ltd.*, 149 F. 3d 987, 990, 997 (9th Cir. 1998); *Elvis Presley*, 349 F.3d at 990, 997 (9th Cir. 2003).

²⁷⁷ See *supra* n. 264-68 and accompanying text.

themselves that they were in fact viewing a documentary and not a mere copy sold for the same purpose as the copyrighted work.²⁷⁸

Even a film-maker who comports herself with the same probity as the defendants whose fair use defense carried the day chooses to roll the dice, and assert fair use when sued. Though the film-maker may be confident in her case because she has competent copyright counsel, she still has to reckon with what one film-maker has called the ultimate “chokepoint of rights”:²⁷⁹ the Errors and Omissions (E & O) insurer.

V. E & O INSURERS AND FAIR USE

A. THE GATEKEEPER

Errors & Omission (E&O) insurance, known as a type of media liability coverage, is akin to malpractice insurance. It compensates third parties for the negligent mistakes of the insured.²⁸⁰ No film can be exhibited and distributed in any venue, be it theatrical, cable or network broadcast, or DVD, unless the film-maker has an E & O policy.²⁸¹ The president of one media liability insurer has said, “An uninsured film is an un-releasable film.”²⁸² E & O insurance is the most important gatekeeper for a documentarian’s fair use assertion.²⁸³

The policy indemnifies and pledges to defend any claims arising from infringement suits. The insurance protects investors, exhibitors, and

²⁷⁸ *Id.*

²⁷⁹ AUFDERHEIDE & JASZI, *UNTOLD STORIES*, *supra* note 49, at 9 (quoting filmmaker Jon Else).

²⁸⁰ DONALDSON, *supra* note 118, at 198.

²⁸¹ Copyright attorney David Rieff, quoted in HEINS & BECKLES, BRENNAN CENTER FOR JUSTICE, *WILL FAIR USE SURVIVE? FREE EXPRESSION IN THE AGE OF COPYRIGHT CONTROL* 6 (2005); Gibson, *supra* note 116 at 890; DONALDSON, *supra* note 118, at 198.

²⁸² Interview with Leib Dodell, Media Professional Insurance (Sept. 7, 2007).

²⁸³ Interview with Peter Jaszi, Professor of Law at Washington College of Law at American University (Sept. 21, 2007); *see also* Gibson *supra*, note 116, at 890.

distributors from either secondary liability, the loss of up-front investment and potential profits should the film be subject to money damages, or if an injunction is successfully established against the film.²⁸⁴ E & O insurance thus protects not only the film-maker, but mitigates the risk aversion of other parties downstream on the distribution chain.²⁸⁵ Because copyright owners have been increasingly aggressive in policing uses of their work in the past two decades, the need for media liability insurance on the part of content-producers has increased accordingly, and documentarians have not been exempt.²⁸⁶

Documentarians typically defer purchasing E & O insurance until the last possible minute, because independent films are often shot without distribution in place; typically the distributor is the first interested party in the film's existence who will mandate coverage.²⁸⁷ Film-makers seeking E & O insurance do not deal directly with the insurer, but instead fill out an application with a broker.²⁸⁸ The application itself begins with the presumption that any copyrighted material within a documentary has been cleared with formal permission from the owner.²⁸⁹ The form asks if copyrighted materials are included within the film. If so, it then asks if permission to use it has been obtained from the owner. If permission has been denied, the film-maker must explain the refusal.²⁹⁰ In addition, the film-maker must provide a full clearance history of any copyrighted

²⁸⁴Gibson, *supra* note 116, at 890-91.

²⁸⁵Gibson, *supra* note 116, at 890-91.

²⁸⁶Copyright attorney David Rieff attributes the demand for E&O in the media context to high-profile defamation suits by General William Westmoreland against CBS, and by Israeli leader Ariel Sharon against Time Magazine in the 1980's; media companies scrambled for insurance protection from defamation actions, but copyright-related matters came as part of the package; when corporate media entities decided to require the policies for distribution and exhibition, copyright clearance became part of the bargain. Heins & Beckles, *supra*, note 106, at 5.

²⁸⁷DONALDSON, *supra* note 118, at 198.

²⁸⁸Interview with Debra Kozee, President, C & S Ins. Brokers (Oct. 22, 2007).

²⁸⁹Gibson, *supra* note 116, at 890-91.

²⁹⁰DONALDSON, *supra* note 118, at 211.

material included in the film, again explaining any failure to secure permissions.²⁹¹ Finally, the applicant is asked if she has been party to an infringement claims, whether brought to fruition in proceedings, pending, or threatened; this demand extends to claims the film-maker may reasonably believe to potentially exist, within the last five years.²⁹²

The broker then takes the application to insurance company underwriters, who assess the risks, and decide whether to issue the policy, and for how much.²⁹³ Often with the help of counsel, though sometimes drawing on experience, the underwriter, on seeing the absence of permission will analyze two things. First, the broker will determine the likelihood an infringement suit will be filed. Second, if the underwriter even entertains the possibility of accepting fair use, the likelihood the defense will defeat summary judgment is entertained.²⁹⁴ An underwriter facing a potential fair use assertion must weigh the fact that only areas of settled law can be considered by a court deciding a motion for summary judgment.²⁹⁵ As has been shown, the fair use case-law is both scanty with respect to documentaries, and is anything but settled; this is palpably the underwriter's perspective.²⁹⁶ As one broker for documentarians has said, "we never say fair use to an underwriter. Ever. Fair use is a defense, and

²⁹¹ *Id.*

²⁹² *Id.* at 212.

²⁹³ *Id.* at 200-01. Policies for an independent film cost between \$3500 and \$15,000, depending on the means of distribution and the specific insurance needs of those parties; most documentaries, being small-scale production, fall at the low end of the price spectrum. Interview with Debra Kozee, *supra* note 288.

²⁹⁴ Interview with Dodell, *supra* note 282, Interview with Ken Goldstein, Worldwide Media Liability Manager, Chubb Specialty Insurance (Oct. 27, 2007); Interview with Michelle Tilton, President, First Media (Jan. 17, 2008); Interview with Paul Paray, Senior Vice President, HRHInsurance, formerly underwriter at AIG.

²⁹⁵ DONALDSON, *supra* note 116, at 201.

²⁹⁶ Interview with Dodell, *supra* note 282.

underwriters don't want to get to the point where they're defending a claim."²⁹⁷

Prior to 2007, of the four major media liability insurers in the documentary field, one, AIG, flatly refused to cover un-cleared material.²⁹⁸ The other three, Media Professional, First Media, and Chubb, would, on a case-by-case basis, accept an opinion letter from the film-maker's copyright counsel for review in the underwriting process.²⁹⁹ Responses to the letters varied. Chubb's underwriters weighed the opinion against their own analysis of the four factors (sometimes turning to clearance counsel), and if there was agreement, Chubb assumed the risk and write coverage confident that their analysis comported with the law.³⁰⁰ In some instances, the policy was priced upwards.³⁰¹ If there was no agreement, coverage was denied.

First Media stressed that it would always urge the filmmaker to work closely with an attorney for clearance issues at the outset of the relationship.³⁰² Unlike Chubb, it looked to the quality and strength of the opinion letter, rather than weighing the opinion against their own four-factor analysis.³⁰³ Media's attitude was that if the film-maker (and her counsel) showed they had conducted due diligence, they would provide coverage.³⁰⁴ Media's underwriters have even, in the absence of an opinion letter, watched the film themselves to determine fair use, and if a problem

²⁹⁷Debra Kozee, President of C&S Int'l Ins. Brokers in New York, *quoted in* Kimberly Brown, *Copyright Versus Creativity*, REALSCREEN, ¶ 8 (June 6, 2005), <http://www.realscreen.com/articles/magazine/20050601/copyright.html>.

²⁹⁸Interview with Paul Paray, *supra* note 294. Paray described AIG's practice as a built-in safeguard against infringement claims. *Id.*

²⁹⁹ Interview with Dodell, *supra* note 292; Interview with Goldstein, *supra* note 294; Interview with Tilton, *supra* note 294.

³⁰⁰ Interview with Goldstein, *supra* note 294.

³⁰¹ *Id.*

³⁰² Interview with Tilton, *supra* note 294.

³⁰³ *Id.*

³⁰⁴ *Id.*

was evident, would steer the film-maker to counsel for advice that would bring the use in line with fair use.³⁰⁵

Media Professional also looked to a persuasive opinion letter from competent copyright counsel in covering un-cleared material.³⁰⁶ The letter was important, because MediaPro's president acknowledged "underwriters are not lawyers, they do not view things through the legal lens, are not capable of legal judgment."³⁰⁷ Even if an opinion favored the user, the cost of litigation that the use might incur was still the bottom line.³⁰⁸

Film-makers aver that insurers, even those who will accept an opinion letter, will typically not accept uncleared material.³⁰⁹ On the other hand, Debra Kozee of C & S Insurance Brokers, who served as an intermediary for insurers and documentarians for twenty years, describes it as a fallacy to say coverage was not available where fair use was asserted; documentarians as a breed are just too poor to pay much beyond the \$3500 E & O policy, particularly when the film had yet to recoup its investment; and that as far as underwriters were concerned, \$3500 did not cover exhaustive legal vetting and subsequent litigation expenses. Such litigation can cost between \$290,000 and \$1million.³¹⁰ The consequences of a plaintiff's verdict can run from statutory damages of \$30,000 per infringing use, up to \$150,000 if the infringement is found to be willful, as well as actual damages and attorney's fees.³¹¹

The insurer's reluctance to endorse a film-maker's fair use, no matter how strong a copyright counsel may believe the defense to be, is

³⁰⁵ *Id.*

³⁰⁶ Interview with Dodell, *supra* note 294.

³⁰⁷ *Id.*

³⁰⁸ *Id.*

³⁰⁹ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 23-24.

³¹⁰ Jennifer E. Rothman, *supra* note 119, at 1901 n. 23.

³¹¹ 17 U.S.C. § 504. One film-maker has opined that "every dub [disc or copy of a film, not necessarily for commercial dissemination] you make can be construed as a separate infringement." Robert M. Goodman, *The Boundaries of Copyright*, DIGITAL VIDEO MAGAZINE (June 2006).

inextricably bound up with the uncertainty of a litigation outcome.³¹² The level of uncertainty tolerated by attorneys is not acceptable to insurers.³¹³ As copyright lawyer Michael Donaldson puts it, “Insurers would rather avoid litigation than win litigation.”³¹⁴

Documentarians’ fair use assertions were just not worth the money from an insurer’s litigation standpoint.³¹⁵ This may also be true from the film-makers standpoint. Even if she can find an attorney to furnish a persuasive opinion letter to a sympathetic underwriter, the additional expense of getting “lawyered up” stretches a documentary’s slender budget to the breaking point.³¹⁶ Moreover, film-maker’s may have pragmatic reasons to avoid pressing fair use assertions on their insurers.³¹⁷ One documentarian has said, “if you ever have a claim on E & O insurance, you

³¹² Dodell, *supra* note 282.

³¹³ Interview with Anthony Falzone, Executive Dir., Fair Use Project, Stanford University (Oct. 3, 2007). In late 2007, after the four principle media liability insurers who provide E& O coverage to documentarians had signed on to fair use formally, when asked whether the fair use case law was settled with respect to documentaries, copyright attorney Michael Donaldson replied “absolutely;” Media/Professional Insurance President Leib Dodell said “it’s completely unsettled.” Telephone Interview with Michael Donaldson, *supra* note 73; Interview with Lieb Dodell, *supra* note 828.

³¹⁴ DONALDSON, *supra* note 118, at 207.

³¹⁵ AUTHOR QUESTION

³¹⁶ “[Non-profit] foundations [who often finance documentaries] don’t want to see their limited money going just to lawyers to make contracts, they want it as much as possible to go into production.” Film-maker Jon deGraaf, quoted in AUFDERHEIDE & JASZI, *UNTOLD STORIES*, *supra* note 49 at 28. “And, if the filmmaker’s distributor is a for-profit entity, an insurer might deny coverage for that very reason; the producers of *Z-Channel: A Magnificent Obsession*, said that when he floated fair use past his E & O insurer, the assertion was nixed because of the film’s for-profit status. Internet Movie Database, *supra* note 90. See Paul Cullum, *Copyright and Its Discontents*, L.A. WEEKLY (Oct. 16, 2006).

³¹⁷ *Id.*

might as well go into another line of work. You can never file a claim or you get blacklisted – and never insured again.”³¹⁸

B. THE E & O INSURER AS COPYRIGHTER

E & O insurers shape documentary practice via the power to deny coverage to un-cleared material that satisfies the statutory fair use factors; what insurers do can determine what winds up on screen, and thus they can affect film-makers, either for timidity or boldness.³¹⁹ Representatives of all four major insurers who provide E & O coverage to documentarians concurred with the characterization that, with respect to fair use, the insurer is a policeman for the copyright regime, making certain that the film-maker walks the line between fair use and infringement. Because insurers so often deny coverage where permission was not granted, their gate-keeping role favors copyright holders rather than film-maker.³²⁰ This makes them the de facto regulator in a copyright system that is, at least with respect to infringement actions, an unregulated matter of private ordering.³²¹

The unregulated nature of copyright may seem surprising, given that it is the creation of a long and complicated Congressional statute, and governs a global media industry, whose contribution to the nation's net wealth is vast. Congress defines copyright's entitlement, subject matter, requirements for protection, exclusive rights due to the creator, and penalties for violating those rights.³²² The role of the Federal Copyright Office is ministerial and non-regulatory, and is largely concerned with registering and tracking copyrighted works.³²³ Enforcement then occurs in

³¹⁸ Documentarian Robert Stone, quoted in AUFDERHEIDE & JASZI, *supra* note 49, at 23.

³¹⁹ Telephone interview with Eric Brass, Gen. Counsel WGBH/Boston Public Tel. (Sept. 12, 2007).

³²⁰ Interview with Dodell, *supra* note 282; Interview with Goldstein, *supra* note 294; Interview with Tilton, *supra* note 294; Interview with Paray, *supra* note 294.

³²¹ Joseph Liu, *Regulatory Copyright*, 83 N.C. L. REV. 87, 101 (2004).

³²² *Id.* at 100.

³²³ *Id.* at 102.

the courts, where judges refine any complexities in the application of the statute on a case-by-case basis.³²⁴

While infringement enforcement is thus judicially administered, it comes about as a matter of private lawsuits.³²⁵ The allocation of rights and responsibilities in the market, such as licensing, is not regulated, as it is not defined in the Copyright Act. Between Congress' definitions of the copyright entitlement and judicial enforcement (with the attendant refinements of doctrines like fair use), the copyright regime relies upon private parties to create the structure of the market for expressive creative works.³²⁶

Fair use is a captive of this private ordering. Due to risk-averse behavior, notably on the part of insurers, but also on the part of film-makers and their financiers, it is not a subject of much litigation.³²⁷ Licensing markets tend to dictate the scope of copyright entitlements because of the absence of coherent fair use case-law precedent that lend authority to owners or users, and because film makers, guided in part by insurance considerations, are gun-shy about asserting fair use.³²⁸ Fair use in practice is dictated less by the Copyright Act of 1976 and decisional law, and more by marketplace actors' day-to-day behavior.³²⁹ An independent licensing culture, where documentarians must seek permission for copyrighted materials when they may have a legitimate fair use, supersedes positive law as the determinant of the actors' behavior.³³⁰ As James Gibson writes, these actors, "look to the internal practices of the relevant industries and then apply the same market-referential standards that they would expect the courts to apply if they were ever to litigate," with risk-aversion

³²⁴ *Id.* at 101.

³²⁵ *See generally id.* at 155.

³²⁶ *Id.* at 101.

³²⁷ *See* Gibson, *supra* note 117, at 887-95.

³²⁸ *Id.* at 884.

³²⁹ *Id.* at 887.

³³⁰ *Id.* at 900.

the primary consideration for film-makers.³³¹ Into this vacuum, created by this absence of positive law inputs and regulation, steps the film-maker's insurer.

Insurers increasingly play the traditional governmental roles of risk-spreading and loss prevention.³³² Just as in the private regulatory universe of tort law generally, liability insurance has the capacity to translate the specific tort of copyright infringement's incentives into prices, and more importantly, directives.³³³ In the fair use context, in theory regulation by insurance is facilitative, in that the E & O insurer spreads the cost of losses arising from infringement actions, and thus permits film-makers, investors, exhibitors, and distributors to proceed in their activities, rather than be inhibited by the possibility a risk may become a loss.³³⁴

When an insurer elects to cover a documentarian's exercise of fair use, insurance abates the potential cost of copyright infringement in a world where new creative works build upon and transform older creative works.³³⁵ The fair-use friendly insurer thus enables and facilitates the creation of new documentaries. Conversely, in the more likely scenario that the insurer denies coverage to a documentarian invoking fair use, the owner-friendly licensing market is reified and enabled by the denial, and the insurer has successfully, if inadvertently, policed the content industry's copyright, without recourse to courts, legislators, regulation.³³⁶

Copyright regulation by insurance inheres in the insurer's power to refuse the risk of fair use, which creates leverage over the insured film-

³³¹ *Id.*

³³² Tom Baker & Thomas O. Farrish, *Liability Insurance and the Regulation of Firearms*, in *SUING THE GUN INDUSTRY*, 292 (Timothy D. Lytton ed., University of Michigan Press 2005).

³³³ *See id.*

³³⁴ *See id.* at 294-95.

³³⁵ *See* Dave McNary, *Insurance for Documentary 'Fair Use'*, *VARIETY*, Feb. 22, 2007, available at http://www.variety.com/index.asp?layout=print_story&articleid=VR1117960027&categoryid=13

³³⁶ *See* Gibson, *supra* note 116, at 898-900.

maker.³³⁷ And if the insurer accepts the fair use risk, this gives the insurer incentive to manage the risk both before and after it matures into a loss.³³⁸ Leverage and incentive translates into several broad categories of regulation by insurance: gate keeping, loss prevention, selective exclusion, management of loss costs, and education.³³⁹

The insurer's gate keeping role is elementary in the documentary context: a film-maker's contracts with distributors and exhibitors mandates E & O coverage to protect those third parties, by covering losses they might be exposed to in an infringement action.³⁴⁰ In the copyright context, to get through that gate, documentarians are either compelled to drop any un-cleared footage as soon as it has been disclosed to the insurer, or have the film vetted by an attorney, who then furnishes an opinion letter for the underwriter to either accept or reject.³⁴¹ In both of these scenarios, the film-maker must meet the insurer's standards if she wants to pass through. The insurer chooses whether to permissively regulate fair use by assessing whether the risk comports with existing law, deny coverage if its risk analysis does not jibe with the opinion letter, or affirmatively regulate an owner-friendly copyright regime by a per se exclusion of un-cleared footage.³⁴²

These last two choices fall under another quasi-regulatory category, selective exclusion, wherein an insurer denies the use of un-cleared footage because the underwriter has deemed the potential loss too uncertain, given the instability of judicial readings of the four factors. (Pre-2007, this was AIG's policy.)³⁴³ Selective exclusion of un-cleared footage effectively eliminates the liability altogether.

³³⁷ See Baker & Farrish, *supra* note 332, at 294-95.

³³⁸ See *id.* at 295.

³³⁹ See *id.* at 294-99.

³⁴⁰ See *id.* at 294.

³⁴¹ See Interview with Kenn Goldstein, *supra* note 294.

³⁴² See *id.*

³⁴³ Telephone interview with Debra Kozee, *supra* note 289; however, often when an insurer would offer indemnification and defense for all elements of a documentary except the un-cleared footage; the film-maker, exercising

An insurer practices loss prevention to prevent harm, once it has assumed responsibility for any consequences for a given harm.³⁴⁴ In the context of fair use, this translates into underwriting procedures that make loss prevention activities a condition of obtaining insurance, such as the film-maker's jettisoning of any un-cleared materials, or else an attorney's opinion letter vouching for fair use; risk-based pricing, such as Chubb's increase in premium costs proportional to the heightened degree of risk once it had accepted a film-maker's fair use assertion; and engaging in loss prevention-oriented monitoring in the course of the entire insurance relationship, typified by First Media's recommendation at the outset that the film-maker acquire copyright counsel to vet the film at every step, followed as well by Media Pro and Chubb.³⁴⁵

Finally, the insurer can influence the behavior of the documentarian through education.³⁴⁶ Insurers who deal with film-makers' copyright issues have the benefit of years of experience weighing fair and unfair uses, and accordingly formulate basic principles for the film-maker before the relationship even formally begins. This will direct the film-maker's decision-making so that it is harmonious with the insurer's requirements.³⁴⁷ Media Pro, First Media, Chubb, and the brokerage C & S all issue press releases and print articles on their websites providing overviews of fair use and its attendant case-law, typically stressing the importance of competent counsel and advising cautious behavior by prospective film-maker/insureds.³⁴⁸ In addition, insurers attend seminars

considerable nerves, might then roll the dice by accepting the exclusion, and retaining the footage. *Id.*

³⁴⁴ Baker & Farrish, *supra* note 332, at 295.

³⁴⁵ Interview with Michelle Tilton *supra* note 294; Interview with Leid Dodell *supra* note 282; Interview with Kenn Goldstein, *supra* note 294; Interview with Paul Paray, *supra* note 294; For *See generally* Baker & Farrish, *supra* note 332, at 295 (providing additional background on insurer loss prevention activities).

³⁴⁶ *See generally* Baker & Farrish, *supra* note 332, at 297-98.

³⁴⁷ *See* Gibson, *supra* note 116, 893-94.

³⁴⁸ Media/Professional Insurance, *Documentary Filmmakers Find Freedom from 'Clearance' Hurdles Thanks to Initiative by Media/Professional Insurance and Leading Lawyers*, <http://www.mediaprof.com/documents/Fair>

and workshops at documentary organizations' events, and maintain a press profile, furnishing quotes in trade journals on the rights and responsibilities of film-makers and insurers alike with respect to fair use.³⁴⁹ In this way, the insurers can advertise their products, while providing film-makers working their way through the permissions maze with ex ante advice drawn from expertise and experience.

C. THE ATROPHIED FAIR USE MUSCLE AND A SHOT ACROSS THE BOW

By 2004, Michael Moore's *Fahrenheit 9/11* raised documentary films profile by achieving record box office grosses for the genre and raised the genre's profile to a summit.³⁵⁰ However, the consensus among film-makers, their copyright counsel, and academic commentators was that, as far as documentaries were concerned, "fair use was broken."³⁵¹ Documentarians who had experienced clearance hassles and whose efforts at invoking fair use had not passed muster with insurers commented: "Fair use has never been my friend...and my advice to would be to cover your

%20Use%20News%20Release.pdf (last visited Apr. 28, 2004); Blake Keating, *The Uncertain Applicability of "Fair Use,"* http://www.firstmediainc.com/insights/ip101_iss4.pdf (last visited Apr. 28, 2004); Chubb Group of Insurance Companies, *Errors and Omissions Liability Insurance for Video and Film Producers*, <http://www.chubb.com/businesses/csi/chubb9538.pdf>; C&S International Insurance Brokers, *Producer's E & O*, <http://www.csins.com/prodins/eando.shtml> (last visited Apr. 28, 2004).

³⁴⁹ See, e.g., Jason Fahmy and Kevin Violette, *Playing Fair: The Basics of Fair Use* (Chubb generated article posted at non-theatrical filmmakers' online journal CINE newsletter), <http://www.cine.org/newsletter/newsletter.php#4> (last visited 6/27/09); Dave McNary, "Insurance for Documentary Fair Use," *Variety* online, 2/22/07 (Leib Dodell of Media/Pro quoted in show business trade organ), <http://www.variety.com/article/VR1117960027.html?categoryid=18&cs=1> (last visited 6/27/09).

³⁵⁰ See BRET TOPLIN, *MICHAEL MOORE'S 'FAHRENHEIT 9/11: HOW ONE FILM DIVIDED A NATION* (University of Kansas Press 2007).

³⁵¹ Telephone interview with Anthony Falzone, *supra* note 315.

tracks.”³⁵² “If you’re doing a feature DVD or for theaters, you can’t invoke fair use . . . You can say whatever you want, but at the end of the day you can’t sell your film.”³⁵³ “Fair use is a defense. If someone is suing you, you’re already in the situation where you would have had to have the money to hire a lawyer . . . which is already out of the range of most filmmakers.”³⁵⁴

Veteran copyright attorney and general counsel to the International Documentary Association Michael Donaldson stated that he won many fair use negotiations with insurers, but it was challenging.³⁵⁵ Winning fair use negotiations for Donaldson was always a fight. It was a cumbersome, lengthy process, made doubly painful because it occurred so late in the life of a film, shortly before release, but after the documentarian had spent years in production.³⁵⁶ Any fair use victories with insurers were generally kept secret, so no precedent could be built upon them, and the wheel was reinvented in an ad hoc fashion with each fair use assertion.³⁵⁷ Donaldson said that he was aware of some documentarians who had felt so thwarted by the clearance process and subsequent denials of fair use by insurers that they often abandoned projects at their inception.³⁵⁸ One insurer said that her client Michael Moore, the most commercially successful and well-capitalized figure in the field, has described insurance as his biggest production headache.³⁵⁹

³⁵² AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 24 (quoting Filmmaker Jan Krawitz).

³⁵³ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 25 (quoting Filmmaker Robert Stone).

³⁵⁴ *Id.*

³⁵⁵ Telephone interview with Michael C. Donaldson, *supra* note 73.

³⁵⁶ *Id.*

³⁵⁷ *Id.*

³⁵⁸ *Id.*

³⁵⁹ Telephone Interview with Michelle Tilton, *supra* note 294.

Copyright scholars in legal academia seized upon the problems of documentarians and their insurers as evidence that even the most sympathetic users, whose work so often falls under the § 107 enumerated purposes of criticism, comment, research, scholarship and news, were blocked from availing themselves of effective fair use.³⁶⁰ James Gibson termed the fair use logjam “doctrinal feedback.”³⁶¹ Doctrinal feedback occurs when copyright’s entitlement swallows up fair use, not within the realm of positive law, but through an accretion of unrelated industry customs and practices which inadvertently reinforce the necessity of seeking licenses even where the use is fair.³⁶²

Gibson’s thesis laid out the preconditions of doctrinal feedback: risk aversion of documentarians, their insurers, and their distributors, faced with the legal uncertainties of fair use, breeding overly conservative permission-seeking.³⁶³ The shadow the fourth fair use factor, effect on the market, casts on any *ex ante* decision-making, because of the inherent circularity where *any* appropriation can be found unfair if permission had *ever* been sought in the past by anyone, or even could potentially be sought.³⁶⁴ Owner’s rent-seeking propensities, via unreasonably high clearance fees, reinforced by the practice of major corporate entities to license everything at the maximum price,³⁶⁵ and documentarians own ambivalent respect for a pro-licensing norm, given that their own work can be subject to similar appropriation.³⁶⁶ Gibson concluded that even if all of these motivations are rational and innocent, the solicitude shown by all

³⁶⁰ Aufderheide, *supra* note 139; Gold, *supra* note 110; HEINZ & BECKLES, *supra* note 106, at 6, 18; Jaszi, *supra* note 136, at 717; LESSIG, FREE CULTURE, *supra* note 4, at 95-99; Marques, *supra* note 124; Rothman, *supra* note 119, at 1972-74.

³⁶¹ See generally Gibson, *supra* note 116.

³⁶² See *id.* at 887-903.

³⁶³ *Id.* at 887-903.

³⁶⁴ *Id.* at 896.

³⁶⁵ *Id.* at 902.

³⁶⁶ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49 at 23.

parties to owner's self-aggrandizing strategic licensing behavior ultimately subverted the constitutional knowledge-creation purpose of the Copyright Act, while acting entirely outside the realm of positive law.³⁶⁷

If, as Gibson implied, documentarians' fair use impasse arose from custom and practice, and was a collective action problem, then, perhaps, only a collective action solution could break it. As one documentarian put it, "[fair use is] like a muscle. You have to use it."³⁶⁸ Beginning in 2004, film-makers, assisted by lawyers and academics, began to flex that muscle. That year, the Center for Social Media at American University produced a study entitled "Untold Stories: Creative Consequences of the Rights Clearance Culture for Documentary Filmmakers," authored by academic and copyright lawyer Peter Jaszi and communications scholar and center director Pat Aufderheide.³⁶⁹

"Untold Stories" was the product of interviews with 45 documentarians about their clearance difficulties and the inadequacy of fair use as a cure.³⁷⁰ The authors concluded that the inaccessibility of licenses, due to either exorbitant costs or rights-holders' reluctance to part with the material, had resulted in films whose message was diluted, and sometimes in films not being made at all.³⁷¹ These "untold stories" were prima facie evidence of a shrinking public domain and the need for a stronger, more effective fair use.³⁷² The study also concluded that many film-makers—as well as lawyers, distributors, and broadcasters—lacked a full understanding of the doctrine, and called for greater educational efforts so that such misunderstandings would not continue to be a hindrance to the application of fair use.³⁷³ Finally, the study identified insurers as "the chokepoint of rights," a gatekeeper who, if swayed, could break the fair use impasse.³⁷⁴

³⁶⁷ See generally Gibson *supra* note 116, at 903-906.

³⁶⁸ AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49 at 28 (quoting filmmaker Sam Green).

³⁶⁹ *Id.*

³⁷⁰ *Id.*

³⁷¹ *Id.* at 29-30.

³⁷² *Id.* at 6-7.

³⁷³ Aufderheide, *supra* note 139, at 29.

VI. THE DOCUMENTARY FAIR USE SEA-CHANGE

A. BEST PRACTICES

Among the recommendations in “Untold Stories” was a call for film-makers to craft a including: encouraging documentarians to rely on fair use whenever reasonable; persuading gatekeepers, including insurers, to accept well-founded assertions of fair use; discouraging copyright owners from threatening or bringing infringement suits against documentarians when the use comported with best practices;³⁷⁵ and, should such a suit be brought, providing film-makers with an evidentiary basis for a fair use defense, if their use complied with best practices.³⁷⁶

“Untold Stories” co-author Peter Jaszi noted that the fair use case-law, particularly the nonfiction film cases, used the four § 107 factors as a covert means of determining whether the film-maker appropriated copyrighted material for a legitimate documentary purpose, or for mere free riding, commercial exploitation, or creation of market substitute.³⁷⁷ The fair use inquiry thus compares the defendant’s actual practice and the norm or pattern of use with which that defendant seeks to affiliate: documentary knowledge-creation, or mere piracy.³⁷⁸ Therefore, if film-makers could, as a group, articulate fair use custom and practice, then courts, as well as gatekeepers, would be on firmer ground when weighing a fair use assertion.³⁷⁹

³⁷⁴ See AUFDERHEIDE & JASZI, UNTOLD STORIES, *supra* note 49, at 9.

³⁷⁵ See *id.* at 31.

³⁷⁶ See *id.* at 30-31.

³⁷⁷ Peter Jaszi, *Copyright, Fair Use and Motion Pictures*, 1 UTAH L. REV. 715, 720 (2007).

³⁷⁸ *Id.* at 731. Such a reading of the cases makes the harshest judicial denial of fair use, *Elvis Presley Enterprises v. Passport Video*, seem less harsh, if a documentarian were to use the case as a boundary-marker for “transformativeness,” as well as a caution not to actually advertise her film based on the copyrighted material included. See Aufderheide, *supra* note 139, at 29.

³⁷⁹ *Id.* at 732.

In a series of thirteen meetings, Jaszi and Aufderheide worked with members of five filmmaker organizations³⁸⁰ to articulate principles of fair use and limitations on those principals; the findings were then vetted by a legal advisory board, and the results, The Documentary Filmmakers' Statement of Best Practices in Fair Use ("the Statement"), was issued on November 18, 2005.³⁸¹

The Statement lists four situations where documentarians may reasonably assert fair use, and for each situation articulates a fair use principle, each with an attendant limitation.³⁸² While the situations came from the experiences of participating film-makers, the principles were synthesized from extant documentary fair-use case law, with particular attention paid to the requisite transformative inquiry.³⁸³ In addition, the Statement folds the first "purpose and character of the use" into the third "amount and substantiality" factor to ask whether the amount taken was appropriate in light of the nature of the copyrighted work and the purpose of the use.³⁸⁴ The situations where documentarians may assert fair use include:

- 1) Employing copyrighted material as the object of social, political, or cultural critique; the underlying principle here reflects the enumerated fair use purposes in the act. The Statement notes that so long as the film-maker analyses or comments on the copyrighted material, and uses it only as extensively as her point is made, then the use is fair. The limitation flows from the last point, in that the appropriated work cannot be used so much that the use becomes a substitute for the original.

³⁸⁰ PAT AUFDERHEIDE ET AL., CENTER FOR SOCIAL MEDIA, DOCUMENTARY FILMMAKERS' STATEMENT OF BEST PRACTICES IN FAIR USE 1 (2005), *available at* http://www.centerforsocialmedia.org/files/pdf/fairuse_final.pdf.

³⁸¹ Aufderheide, *supra* note 139, at 30; *see also* AUFDERHEIDE ET AL., *supra* note 380, at 1.

³⁸² AUFDERHEIDE ET AL., *supra* note 380, at 5-7.

³⁸³ *Id.* at 3-4.

³⁸⁴ *Id.* at 4.

2) Quoting copyrighted works of popular culture to illustrate an argument or point; an example given is the use of a film clip to depict changing attitudes towards race. The illustrative power of such a use, subordinated to the intellectual or artistic purpose of the documentary, renders any entertainment value inherent in the original work irrelevant, because the original is being transformed for a new purpose, rather than free-riding. The limitations include: Proper attribution; drawing from a range of sources as much as possible; using no more than necessary to make the point; and not employing the quoted material in order to avoid shooting equivalent footage.

3) Capturing copyrighted material in the process of filming something else. Here, tampering with reality by removing the captured work would be in violation of documentary practice. The limitations include: not requesting or directing that the media content be in the scene, a manipulation of reality unacceptable to documentarians anyway; the captured material must in some way be integral to the scene; it must be attributed; the captured content should not be there purely to be exploited by being the scene's sole point of interest; and if what is captured is music, it must not functionally be used as a synchronized soundtrack, that is, the scene must not be edited to the rhythm of the music, or it cannot carry over into another scene.

4) Using copyrighted material in a historical sequence. Acknowledging that the best way to create historical context may be the use of words, images or music connoting the period; often this material is available on reasonable licensing terms, but sometimes the cost is exorbitant, or the owner otherwise refuses permission. The principle stated is that due to the importance of historical matter, in some instances fair use should apply. But here the limitations are more stringent: the film must not be designed around the material used; the film does not disproportionately rely upon a single source; the material must serve a critical illustrative point; no suitable substitute for the copyrighted material can exist; no more should be taken than to make the point; no license is available, or the licensing fee is excessive in proportion to

the documentary's budget; and the material must be properly attributed.³⁸⁵

Remarkably, almost before the ink was dry on the Statement, it had an almost immediate impact upon the gatekeepers.

B. THE BELLWEATHER FILMS AND THE INSURERS

Eight weeks after the Statement's release, three documentarians successfully invoked its principles to justify their reliance upon fair use when all three premiered films at the Sundance Festival.³⁸⁶ "This Film Is Not Yet Rated," which examined the arbitrary and capricious standards of the Motion Picture Association of America's ("MPAA") film rating board, used 143 film clips from Hollywood movies to illustrate that the ratings system discriminated against independent films.³⁸⁷ The film-makers quickly realized that given the critical posture the film took towards both Hollywood's depiction of sex and violence and the MPAA rating practice, it would be impossible to secure licenses.³⁸⁸ Primarily because through criticism of the film quoted, "This Films'..." violated standard form language in studio licensing agreements³⁸⁹ thus fair use was the only feasible means of producing the film.³⁹⁰

The second Sundance film debut invoking fair use was "The Trials of Darryl Hunt," recounting the vindication of a wrongfully accused man facing life in prison for rape and murder after a racially-charged trial.³⁹¹ A local broadcast outlet had permitted the use of news footage, but when the licensor decided it wanted to make its own documentary on the subject, permission was withdrawn; the film-makers stood their ground, asserted

³⁸⁵ *Id.* at 6-7.

³⁸⁶ Jaszi, *Copyright*, *supra* note 136, at 734.

³⁸⁷ Paul Cullum, *supra* note 89, at 1.

³⁸⁸ *Id.* at 1, 3.

³⁸⁹ *Id.* at 3.

³⁹⁰ Elaine Dutka, *supra* note 94, at 16.

³⁹¹ Jaszi, *Copyright*, *supra* note 136, at 734-35.

fair use, and used the footage anyway.³⁹² The final Sundance film screened under the Statement's aegis was "Hip-Hop: Beyond Beats and Rhymes;" this film quoted substantially from songs and music videos to critique rap music's celebrations of misogyny and violence.³⁹³ Taking on the music industry, the most proprietary of content-owners, "Hip-Hop's" makers relied on fair use and the Statement, as their film was unquestionably quoting in the service of criticism and commentary.³⁹⁴ Releasing a film employing uncleared material through festivals is one thing, as festival rights clearance is a pro forma affair. However, all three films went on to either theatrical or broadcast distribution, and eventual DVD release.³⁹⁵ Additionally, the broadcast outlets that aired the films, including ITVS, PBS, HBO and the Independent Film Channel, accepted the three filmmaker's fair use assertions based on the Statement.³⁹⁶ This was only possible because insurers had first accepted fair use.³⁹⁷ Subsequently, key

³⁹² *Id.* at 735.

³⁹³ *Id.*

³⁹⁴ *Id.*

³⁹⁵ There were no negative repercussions from rights owners. Of the films, the one which was almost entirely dependent on un-cleared clips was "This Film is not Yet Rated." Michael Donaldson has stated "there was not one peep from the studios." Telephone Interview with Michael Donaldson, *supra* note 296; "I used fair use, and they couldn't do anything about it," said Kirby Dick. Interview with Kirby Dick, Documentary Film Director (Sept. 21, 2007).

³⁹⁶ Interview with Pat Aufderheide, Director, Center for Social Media (Sept. 21, 2007). The Independent Film Channel, which aired "This Film is Not Yet Rated" went so far as to incorporate the Statement into its own internal procedures: Evan Shapiro, the cable network's general manager, had vowed not to get involved with clip-heavy films after producing "Z Channel: A Magnificent Obsession," but after accepting "This Film is not Yet Rated" he announced that all of IFC's documentaries would embrace fair use from then on. Dutka, *supra* note 393, § 2, at 16; Jaszi, *supra* note 136, at 735. PBS, which aired "Hip-Hop," accepted the film under the Statement, and its general counsel internally disseminated the document to all counsel and general managers within its affiliates. Aufderheide, *supra* note 139, at 34.

³⁹⁷ Aufderheide, *supra* note 139, at 34.

insurers went further than the usual ad hoc fair use acceptance which bore no precedential impact.³⁹⁸ Within a year, two insurers would announce formal fair use endorsements. Two others, while continuing their pre-Statement ad hoc fair use underwriting, would align themselves publicly with the two furnishing endorsements.³⁹⁹

C. THE FAIR USE ENDORSEMENT

Of the seven insurers who handle the E & O needs of documentarians, four of them: AIG, Media/Professional, Chubb and First Media represent the bulk of the market.⁴⁰⁰ In early 2007 both AIG and Media/Pro came out with endorsements affirmatively providing coverage for fair use.⁴⁰¹ AIG's acceptance of fair use was particularly noteworthy, because hitherto it had per se excluded uncleared footage.⁴⁰² The endorsements came about through a convergence of several discrete parties operating independently, all of whom had been motivated towards the same goal by momentum generated by the Statement.⁴⁰³

1. *AIG's Fair Use Doctrine*

AIG's turnabout was precipitated by Debra Kozee, President of C & S Insurance Brokers, and Peter Jaszi.⁴⁰⁴ Kozee had been acting as an insurance intermediary for several years, and had both a business and personal commitment to documentarians⁴⁰⁵. In January of 2007, she was

³⁹⁸ Telephone Interview with Debra Kozee, *supra* note 289.

³⁹⁹ *Id.*

⁴⁰⁰ *Id.*

⁴⁰¹ *Id.*

⁴⁰² Telephone Interview with Paul Paray, *supra* note 294.

⁴⁰³ *Id.*

⁴⁰⁴ Telephone Interview with Debra Kozee, *supra* note 289.

⁴⁰⁵ *Id.*

involved in procuring insurance for “Hip-Hop: Beyond Beats and Rhymes.”⁴⁰⁶ Jaszi, working as copyright counsel for the film-makers, had flagged “Hip-Hop” as a test case for insurers acceptance of fair use, largely because of the film’s use of music and music videos met head-on with the thorniest copyright arena and the most proprietary and litigious class of owners.⁴⁰⁷ Jaszi wrote an opinion letter asserting fair use, and letter in hand, Kozee went out with the film to underwriters for bids.⁴⁰⁸

Paul Paray, an underwriter at AIG, was impressed with the opinion letter.⁴⁰⁹ He believed he discovered a clue on how fair use could be responsibly used by film-makers, due to the fact that expert copyright counsel vetted the film and adequately applied the four factors analysis.⁴¹⁰ Furthermore, Paray concluded that though not dispositive, the factors Statement was a “key” factors in the creation of the endorsement.⁴¹¹ He believed that there was great care used in the creation of the standards⁴¹² and that the Statements represent a good-faith pledge of due diligence.⁴¹³

Shortly afterwards, Paray went to a highly attended film-maker conference on fair use⁴¹⁴ that affirmed the documentarians’ desire to

⁴⁰⁶ *Id.*

⁴⁰⁷ *Id.*; Copyright Attorney David Reiff says “Music is a snakepit.” MARJORIE HEINS & TRICIA BECKLES, WILL FAIR USE SURVIVE?: FREE EXPRESSION IN THE AGE OF COPYRIGHT CONTROL 6 (2005), available at <http://www.fepproject.org/policyreports/WillFairUseSurvive.pdf>, “You have to clear all music.” DONALDSON, *supra* note 118, at 289.

⁴⁰⁸ Telephone Interview with Debra Kozee, *supra* note 289.

⁴⁰⁹ Telephone Interview with Paul Paray, *supra* note 294.

⁴¹⁰ *Id.*

⁴¹¹ *Id.*

⁴¹² *Id.*

⁴¹³ *Id.*

⁴¹⁴ *Id.*

follow the Statement's guidelines.⁴¹⁵ Paray concluded that he would rather have a fair use endorsement than not,⁴¹⁶ thus AIG accepted "Hip-Hop's" fair use assertion and created a formal endorsement scheme.⁴¹⁷ The endorsement was predicated upon an attorney's opinion letter that agreed with the underwriter's analysis of the film under the § 107 factors. (footnote 320).⁴¹⁸

Paray describes AIG's fair use endorsement as helping all parties: film-makers, because they are permitted greater freedom and creativity; insurers, because the decision of underwriters compels documentarians to rely on counsel creating clarity from a claims perspective; and the public, because it gets the benefit of viewing the documentary as the film-maker intended it.⁴¹⁹ He is careful to note that the endorsement is not a substitute for the film-maker's due diligence with respect to acquiring clearance; but because of the opinion letter requirement, the film-maker cannot say, "insurance will cover it, so I'll just take."⁴²⁰

Paray credited Jaszi's advocacy and momentum in the documentary community generated by the Statement as the reason why AIG reversed itself on fair use.⁴²¹ The Statement had fostered film-maker's recognition of the benefits of the involvement of counsel, and this in turn created the template for AIG's endorsement.⁴²² Finally, commerce played a part. Paray believes that public perception of the failure of the mainstream news media in representing the world has significantly raised documentary film's audience profile in the last two decades.⁴²³ The

⁴¹⁵ Telephone Interview with Paul Paray, *supra* note 294.

⁴¹⁶ *Id.*

⁴¹⁷ *Id.*; Telephone Interview with Debra Kozee, *supra* note 289.

⁴¹⁸ Telephone Interview with Michelle Worrall Tilton, *supra* note 294.

⁴¹⁹ Telephone Interview with Paul Paray, *supra* note 294.

⁴²⁰ *Id.*

⁴²¹ *Id.*

⁴²² *Id.*

⁴²³ *Id.*

attendant explosion in documentary production and outlets revealed that a market existed.⁴²⁴ Paradoxically, given the fear of copyright litigation kept fair use from being accepted by insurers, Paray notes that “these policies are profitable from our perspective, because in fact there is very little litigation.”⁴²⁵

2. *Media Professional's Fair Use Endorsement*

Media/Professional's endorsement was the result of a two-front initiative.⁴²⁶ The first approach was made by veteran copyright attorney Michael Donaldson.⁴²⁷ Donaldson worked with documentarians for years and was very hands on with his clients. He often observed his client's work in the editing rooms, guiding them through adherence to legally sound fair use.⁴²⁸ He also served as general counsel to the Independent Feature Project and the International Documentary Association,⁴²⁹ and worked with Jaszi as legal advisor on the Statement. Through workshops and seminars, Donaldson wanted to educate film-makers and industry representatives on the importance of responsible fair use.⁴³⁰ Donaldson has written thousands of opinion letters, and the fact that his clients have never been subject to a fair use cease-and-desist order has made him very comfortable in predicting fair use outcomes.⁴³¹

⁴²⁴ *Id.*

⁴²⁵ Telephone Interview with Paul Paray, *supra* note 294.

⁴²⁶ See telephone interview with Michael Donaldson, *supra* n. 73; see telephone interview with Leib Dodell, *supra* n. 283; see telephone interview with Anthony Falzone, *supra* n. 313.

⁴²⁷ See telephone interview with Michael Donaldson, *supra* n. 73.

⁴²⁸ Telephone Interview with Michael Donaldson, *supra* note 73.

⁴²⁹ *Id.*

⁴³⁰ *Id.*

⁴³¹ Donaldson at IFP Fair Use Summit; See Interview with Anthony Falzone, *supra* note 315. Donaldson is fond of saying “fair use is like bad manners, a spectrum, some clearly good, some clearly bad, much in between.” He describes his job as putting his clients in a safe area by means of his own version of the four-

In the fall of 2006 he began negotiations anew with Media/Professional.⁴³² By February of 2007, Media/Pro had hammered out an endorsement which stated that if one of seven pre-approved attorneys furnished an opinion letter saying a use was fair, the insurer would cover the film.⁴³³

Simultaneously, Media/Professional was working out a different type of deal with Anthony Falzone, an intellectual property litigator and executive director of the Stanford Center for Internet and Society School Fair Use Project.⁴³⁴ Falzone offered to Media/Professional a pro bono defense promise for any covered documentary threatened with an infringement suit.⁴³⁵ Like Donaldson, Falzone would work closely with the film-maker in advance to ensure it comported with responsible fair use.⁴³⁶ Media Pro accepted the offer.⁴³⁷

Falzone, for his part, recognized that when the time comes that the pro bono defense is called in, that scanty documentary fair use case law may be expanded by any litigation that ensues.⁴³⁸ While cautioning that he doesn't want to see any of his clients sued for infringement, he believes that more decisions in the reporters can only help bolster predictability in an uncertain arena.⁴³⁹ Moreover, cease-and-desist letters from owners will

factor test: "Do I need it to tell the story? Is it only sufficient time-wise to make its point? Is it clear why the use makes the point, and does the film itself explain the use? If it doesn't meet this test, I'll tell the film-maker to leave it out." Telephone Interview with Michael Donaldson, *supra* note 73.

⁴³² *Id.*, *supra* note 73. In addition to Media/Professional, Donaldson has worked and continues to work, exclusively with AIG and Chubb. *Id.*

⁴³³ *Id.*; see Telephone Interview with Leib Dodell, *supra* note 283.

⁴³⁴ Telephone Interview with Anthony Falzone, *supra* note 313.

⁴³⁵ *Id.* He has been in talks since with other insurers to work out a similar pro bono defense promise. *Id.*

⁴³⁶ *Id.*

⁴³⁷ *Id.*

⁴³⁸ *Id.*

⁴³⁹ *Id.*

now be getting rapid legal responses from hitherto impecunious film-makers.⁴⁴⁰ Film-makers would gain in confidence knowing someone is standing behind them, while litigious owners will find their bullying ineffective if it looks like the law is on the documentarians side.⁴⁴¹

Media/Professional president Leib Dodell expressed his pleasure because Falzone and his crew of activist attorneys had taken the weight of litigation off of the insurer through shouldering the cost of defending film-makers who adhered to the Statement.⁴⁴² While the “Donaldson Way,” the use of transactional attorneys to ascertain cut-and-dried fair use assertions, was a formalization of Media/Professional’s prior policy, the “Falzone Way” represented something truly novel.⁴⁴³ Dodell said it was ultimately the key element in solidifying his company’s posture towards fair use.⁴⁴⁴ The cost of litigation, a significant barrier to covering even the fairest of uses, evaporated in a heart-beat.⁴⁴⁵ In addition, Dodell acknowledged that the thorough vetting of the films by either the seven approved lawyers or Falzone reduced underwriting costs.⁴⁴⁶

Dodell still believes fair use case law in the documentary context is unsettled, but because of the pro bono promise is now more comfortable with Donaldson’s rejoinder that “it’s absolutely settled.”⁴⁴⁷ Dodell was aware of the historical inconsistency between insurers who were reluctant to accept fair use and attorneys, who were more comfortable arguing the

⁴⁴⁰ Telephone Interview with Anthony Falzone, *supra* note 313.

⁴⁴¹ *Id.*

⁴⁴² Telephone Interview with Leib Dodell, *supra* note 282.

⁴⁴³ *Id.*; Telephone Interview with Michelle Tilton, *supra* note 294; Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁴⁴ Telephone Interview with Leib Dodell, *supra* note 282.

⁴⁴⁵ *See id.*

⁴⁴⁶ *See id.*; Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁴⁷ Telephone Interview with Leib Dodell, *supra* note 282; Telephone Interview with Michael Donaldson, *supra* note 73.

doctrinal boundaries in a defendant's favor.⁴⁴⁸ The insurer was formerly viewed as the policeman or regulator of the fair use system. However Dodell said "the lawyers have taken on the policeman role, they vet everything now."⁴⁴⁹ Since the endorsement was created, Dodell reports (as do Chubb and First National), the fair use litigation front has been calm. Film-makers are happy, no-one has been sued, and financing has opened up.⁴⁵⁰

3. *The Bandwagon*

While the AIG turnabout quietly occurred a month before Media/Professional's fair use endorsement, the latter managed to generate a publicity coup, Hollywood style, that landed the arcane doctrine of fair use on the front page of both *The Hollywood Reporter* and *Variety* the very next morning.⁴⁵¹ In February, 2007, Media/Professional's endorsement was announced by the president of the International Documentary Association, Diane Vicari, at the Los Angeles gala party for the announcement of the Academy Award's Best Documentary nomination.⁴⁵² She brought representatives of each company on state, where the elite of the documentary community greeted them with a thunderous standing ovation.⁴⁵³

The next day, the announcement made the trade paper headlines, and Donaldson received a phone call from a major insurer, outraged that they had not been included in the festivities, or, more to the point,

⁴⁴⁸ Telephone Interview with Leib Dodell, *supra* note 282.

⁴⁴⁹ *Id.*

⁴⁵⁰ *Id.*

⁴⁵¹ Gregg Kilday, *Documakers Getting Aid on Fair Use*, HOLLYWOOD REP., Feb. 23, 2007, available at <http://www.donaldsoncallif.com/press/documakers-getting-aid-on-fair-use/>; Dave McNary, *Insurance for Documentary Fair Use*, VARIETY, Feb. 22, 2007, available at <http://www.variety.com/article/VR1117960027.html?categoryid=18&cs=1>.

⁴⁵² Kilday, *supra* note 451.

⁴⁵³ *Id.*

approached with a similar endorsement proposal.⁴⁵⁴ He then fielded similar phone calls from Lloyd's and AIG.⁴⁵⁵ As the story gained traction in the trades, blogs, and more specialized insurance and film-making news organizations, First Media and Chubb, who had always accepted fair use with an opinion letter, chimed in to align themselves with what now appeared to be an irresistible tide of insurer capitulation to documentarians' fair use assertions.⁴⁵⁶

Donaldson speculated as to why the other two joined in, and why AIG was sure to raise its profile: They wanted to bask in industry applause and retrieve any stolen thunder; exploit a growing demand for a new insurance product; they had been quietly granting fair use already, but a more openly permissive underwriting attitude, and a foregrounding of film-makers' copyright counsel's role, would cut through the ad hoc struggles such assertions bred.⁴⁵⁷ Finally, the opinion letter process ultimately saved them money, if not to the degree Falzone's pro-bono lawyers would on litigation, at least on the underwriting side.⁴⁵⁸ Or, as Debra Kozee more pithily put it, "monkey see, monkey do."⁴⁵⁹

Peter Jaszi has written that the most powerful evidence of the Statement's impact on industry custom and practice, its most stunning success, was the fact that it took a mere eighteen months for the majority of insurers providing E & O coverage to documentarians to cover fair use.⁴⁶⁰ "At least where documentary films are concerned, the vicious circle has become a virtuous circle."⁴⁶¹ While the respective stories of AIG's and Media/Professional's arrival at fair use endorsements are dramatic, with

⁴⁵⁴ Telephone Interview with Michael Donaldson Interview, *supra* note 73.

⁴⁵⁵ See telephone interview with Michael Donaldson, *supra* n. 73.

⁴⁵⁶ *Id.*

⁴⁵⁷ Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁵⁸ *Id.*; see also Telephone Interview with Anthony Falzone, *supra* note 313.

⁴⁵⁹ Telephone Interview with Debra Kozee, *supra* note 289.

⁴⁶⁰ Jaszi, Copyright, *supra* note 136, at 735.

⁴⁶¹ *Id.* (citation omitted).

many forces coalescing into a happy ending, the response by the other primary insurers, Chubb and First Media, offers a slightly different angle on the virtuous circle.⁴⁶²

4. *Marketing v. Substance: Chubb and First Media*

First Media and Chubb historically accepted documentarians' fair use assertions, if accompanied by copyright counsel's opinion letter, and continue to do so.⁴⁶³ Representatives of both companies aver that AIG's and Media/Professional's fair use endorsements are merely cosmetic changes in the underwriting process.⁴⁶⁴

Ken Goldstein of Chubb described the endorsements as "a marketing change, not a substantive change."⁴⁶⁵ He stated that Media/Professional demands an opinion letter identical to what was required prior to February 2007, and gives that letter the same underwriting scrutiny as before, with the same consequences if it finds that the film-maker has failed to satisfy the four factors: denial of coverage.⁴⁶⁶

When asked if Chubb would consider Media/Professional's acceptance of Falzone's pro bono defense promise as a valid option, he unequivocally said no.⁴⁶⁷ This is because Chubb's E & O policy is structured around the documentarian/insured's participation in settlement decisions. Goldstein stated that he wants the film-maker to have "skin in the game," and a pro bono defense promise would both let documentarians

⁴⁶² See Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁶³ See Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁶⁴ See Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁶⁵ Telephone Interview with Ken Goldstein, *supra* note 294.

⁴⁶⁶ *Id.*

⁴⁶⁷ *Id.*

off the hook of making hard choices, and encourage them to avoid asking for a license from a copyright owner at the outset.⁴⁶⁸

Michelle Tillton of First Media called the fair use endorsements “spin,” and stated that any characterization of a “before and after” scenario regarding the four insurers’ handling of fair use was “not valid.”⁴⁶⁹ She believes commerce, and not a particular solicitude for documentarians’ clearance troubles, motivated the endorsements, pointing that the insurance market has been a soft one for well over a year.⁴⁷⁰ Explaining that documentarians E&O policies are “non-reoccurring premium business,” that is, one-year policies without renewal, Tilton believes that Media/Professional’s and AIG’s new products are merely a quick and inexpensive means of collecting new insureds in a soft market, through writing these policies on an ad hoc, one-off basis.⁴⁷¹

However, both Goldstein and Tillton saw some value in the endorsements, not because of innovative underwriting practices, but because of better conduct by documentarians.⁴⁷²

Goldstein believes that insurers are not any more fair use friendly than pre-Statement, but instead that film-makers are more responsible.⁴⁷³ Because the new endorsements require film-makers to have an experienced copyright lawyer thoroughly vet their films, tell them what they can and cannot do, and these decisions are the basis for the opinion letter, then documentarians are being educated in the law.⁴⁷⁴ Film-makers, as a consequence of this education, have shown a good-faith effort to exercise fair use in compliance with the law. This good faith, engendered by the Statement and validated by the availability of the endorsements, will

⁴⁶⁸ *Id.*

⁴⁶⁹ Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁷⁰ *Id.*

⁴⁷¹ *Id.*

⁴⁷² See Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁷³ Telephone Interview with Ken Goldstein, *supra* note 294.

⁴⁷⁴ *Id.*

certainly lead insurers to be more receptive to fair use claims, regardless of whether an endorsement is offered or not.

VII. THE FUTURE

While insurers, film-makers, academics, and attorneys have all expressed optimism for the future of fair use in the documentary field, especially since the insurers have become a more permissive gatekeeper, they also concur that it is too soon to foretell the degree to which documentarian's invocations of fair use will resolve their clearance issues.⁴⁷⁵ However, the players have flagged several key areas of uncertainty, and in some instances have been comfortable with making predictions.⁴⁷⁶ These areas of uncertainty include the response of copyright holders, the thorny areas of music clearance and archival footage clearance, the receptivity of third parties, such as distributors and broadcasters, to fair use assertions already vouched for by insurers and copyright counsel, and the potential for moral hazard when copying is protected by insurance.⁴⁷⁷

A. THE RESPONSE FROM COPYRIGHT OWNERS

A year after the insurer fair use was announced, copyright holders have remained silent litigation-wise with respect to fair use and documentaries.⁴⁷⁸ Anthony Falzone suggested that the silence may owe

⁴⁷⁵ See, e.g., Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁷⁶ See Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁷⁷ See Telephone Interview with Lieb Dodell, *supra* note 282; Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Anthony Falzone, *supra* note 313; Telephone Interview with Michelle Tillton, *supra* note 294.

⁴⁷⁸ See Telephone Interview with Michael Donaldson, *supra* note 73; Telephone Interview with Lieb Dodell, *supra* note 282; Telephone Interview with Ken Goldstein, *supra* note 294; Telephone Interview with Anthony Falzone, *supra* note 313; Telephone Interview with Michelle Tillton, *supra* note 294. Some studio executives however, vented their frustration in the press in 2006, following the Independent Film Channel's acceptance of fair use for a clip-driven documentary about "road movies" called "Wanderlust." The clips requested from the studios exceeded the budget by over \$150,000. Representing the producers, Michael

something to publicity and momentum, specifically with respect to documentarians new-found boldness in asserting fair use, and the speed with which insurers stepped up to support them.⁴⁷⁹ As Falzone explains, “Owners’ counsel’s attention has been attracted to this assertion of a strong positive law basis for fair use, and sense they can no longer bully a filmmaker with cease and desist letters as easily.”⁴⁸⁰ Michael Donaldson believes that after twenty years of education and experience, rights holders, movie studios in particular, “get it now,” and have come to understand fair use in the documentary context knowing when they can sue for infringement.⁴⁸¹ Moreover, now that insurers are visibly on the film-makers side, in the wake of the probability of being met with a strong defense, owners are gun-shy of losing.⁴⁸²

Ken Goldstein of Chubb took the sympathetic view of copyright holders in a fair use scenario.⁴⁸³ Goldstein pointed out that they perceive the use as the loss of a valuable revenue stream, but he agreed that an owner, faced with a legitimate fair use assertion, if furnished with an authoritative explanation of why the law would favor the use, might be relieved to be spared the burden of litigation.⁴⁸⁴ Leib Dodell of Media/Professional, who like the other insurers represents owners as well

Donaldson offered a deal, a token license for \$1,000 a title, or else the film-makers would invoke fair use. 13 of the 18 copyright holders accepted the offer. James Velaise, right’s holder for Jean-Luc Godard’s “Breathless,” and one of the 13 who capitulated, called Donaldson’s offer “blackmail,” the deployment of fair use a “dishonest” ploy to save money, and the use tantamount to stealing. Another unnamed executive said “If someone can’t afford a Mercedes, that doesn’t mean he can’t drive,” suggesting documentarians should find cheap substitutes if they cannot pay for a license. Dutka, *supra* note 94, at 16 (*see also* Correction, N.Y.TIMES, June 4, 2006, § 2, at 8).

⁴⁷⁹ Telephone Interview with Anthony Falzone, *supra* note 313.

⁴⁸⁰ *Id.*

⁴⁸¹ Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁸² *Id.*

⁴⁸³ Telephone Interview with Ken Goldstein, *supra* note 294.

⁴⁸⁴ *Id.*

as users, stated that he has conveyed to owners that the fair use endorsement will ultimately benefit them as well, by sparing them needless litigation headaches.⁴⁸⁵ Pat Aufderheide believes that the Statement can be a litigation tool for owners in infringement suits, as they can point to a defendant's departure from its dictates as *prima facie* evidence that the use was unfair.⁴⁸⁶

Michelle Tillton of First Media elaborated on this point.⁴⁸⁷ Because the four factors cut both ways, potential owner/plaintiffs now have a heightened awareness of litigation costs and the possibility of a court defeat.⁴⁸⁸ She agreed that since an adverse fair use court decision could create precedent that hurts owners in future litigation, that they will choose their legal battles carefully rather than reflexively firing off cease-and-desist letters.⁴⁸⁹ Tillton also opined that the *zeitgeist* and box-office success of Michael Moore's "Fahrenheit 911" have made owners, as aware as the public at large, of the social value of documentaries.⁴⁹⁰ Finally, she believes that policing copyright violations on the internet has kept the content industry sufficiently preoccupied so as to make documentarians fair use assertions a lesser concern.⁴⁹¹

⁴⁸⁵ Telephone Interview with Lieb Dodell, *supra* note 282.

⁴⁸⁶ Pat Aufderheide, Remarks at the I.F.P. Fair Use Summit, *supra* note 399.

⁴⁸⁷ Telephone Interview with Michelle Tillton, *supra* note 347.

⁴⁸⁸ *Id.*

⁴⁸⁹ *Id.*

⁴⁹⁰ *Id.*

⁴⁹¹ *Id.* All of the insurers interviewed agreed with Eric Brass, general counsel of Boston public television outlet GBH's observation that compared to the free-for-all on the internet, documentarians look like responsible users, from a copyright owner's point of view. See Telephone Interview with Debra Kozee, *supra* note 289; Telephone Interview with Paul Paray, *supra* note 294; Telephone Interview with Ken Goldstein, *supra* note 296; Telephone Interview with Michelle Tillton, *supra* note 294.

B. MUSIC

Music presents a more difficult fair use analysis than film clips or incidental captured material because it is harder to distinguish between transformative use and mere use as soundtrack.⁴⁹² While fair use assertion by the producers of “Hip-Hop: Beyond Beats and Rhymes” went unchallenged by music rights holders, one documentarian called music “the next [fair use] frontier (clips being a settled issue).”⁴⁹³ Michelle Tillton of First Media stated pithily, “music always sucks.”⁴⁹⁴

Donaldson and Falzone are comfortable in asserting that a filmmaker who comports with the Statement’s music guidelines are exercising a legitimate use.⁴⁹⁵ Falzone, noting that there have been no challenges to documentarians’ fair use of music recently, says that since the same four-factor analysis in cases involving clips controls, then provided the filmmaker is properly guided by counsel through the editing process, he would have no hesitation about defending a music-based fair use assertion.⁴⁹⁶ Michael Donaldson seconded this statement, saying “music appropriation is now settled.”⁴⁹⁷ He qualified this belief by stating that what he calls “third-party music,” or music not composed for the original film appearing in a film-clip that has been otherwise properly licensed is still unsettled, and an area where he would like to see some cases create certainty.⁴⁹⁸

⁴⁹² Michael Donaldson, Remarks at I.F.P. Fair Use Summit, *supra* note 232.

⁴⁹³ See *supra* text accompanying notes 396-400; David Van Taylor, Filmmaker, Remarks at I.F.P. Fair Use Summit (Sept. 21, 2007). (AUTHOR QUESTION)

⁴⁹⁴ Telephone Interview with Michael Donaldson, *supra* note 73.

⁴⁹⁵ *Id.*; Falzone Interview, *supra* note 313.

⁴⁹⁶ Falzone Interview, *supra* note 313.

⁴⁹⁷ Such is the authority of the Statement; this marks a reversal from Donaldson’s earlier advice to film-makers that all music must be cleared. DONALDSON, *supra* note 145, at 118.

⁴⁹⁸ Telephone Interview with Michael Donaldson, *supra* note 73.

C. ARCHIVE FOOTAGE

Michael Donaldson is wary of one fair use arena that is archival footage.⁴⁹⁹ This is an area where film-makers have had considerable difficulties in securing affordable licenses, and often crucial to the purpose of a historical documentary.⁵⁰⁰ He characterized the depiction of archive houses as monopolistic in “Untold Stories” as greedy as unfair, pointing out that acquisition, digitization, cataloging, preservation, and storage of this often fragile film is extremely expensive, and moreover, is often licensed by the archive owner as well.⁵⁰¹ His advice to film-makers is if they cannot afford a license for archival film, get a suitable substitute elsewhere rather than taking it under fair use, as the Statement provides.⁵⁰² On the other hand, Pat Aufderheide believes that archive houses have responded positively to the Statement on account of its clarity, and that the houses’ litigation posture has diminished since its appearance.⁵⁰³

D. THE RESPONSE OF DOWNSTREAM DISTRIBUTORS

An insurer signing off on a documentary’s fair use of copyrighted material does not guarantee that a distributor will follow.⁵⁰⁴ Because the big commercial players, studios, cable and broadcast networks will continue to unthinkingly pay top dollar for clearance, this precedent of industry custom and practice will always be available for a litigation-shy distributor to point to when it acquires a documentary.⁵⁰⁵ The president of one documentary production company, whose work is largely aired on

⁴⁹⁹ *Id.*

⁵⁰⁰ *Id.*

⁵⁰¹ *Id.*

⁵⁰² *Id.*

⁵⁰³ Pat Aufderheide at IFP Fair Use Summit, Panel Discussion (Sept. 21, 2007).

⁵⁰⁴ *Id.*

⁵⁰⁵ See Marques, *supra* note 124, at 353.

cable, believes that the only arena the post-Statement activity has created a fair use safe harbor for are clip-driven films *about* cultural artifacts.⁵⁰⁶ For anything less on point, distributors may still balk at a fair use assertion despite available coverage.⁵⁰⁷ She explained that in work-for-hire situations, especially in cable or broadcast television, while immediate supervisors may be happy with vetted fair use assertions, corporate resistance at the top still exists.⁵⁰⁸ This resistance will clearly need to be eroded on a company-by-company basis over time, as fair use assertions become more frequent and gain credibility.⁵⁰⁹

E. MORAL HAZARD

The doctrine of moral hazard posits that the presence of insurance creates disincentives on the part of the insured to avoid risk, knowing the insurer is there to pay the bill.⁵¹⁰ Insurers and attorneys all acknowledged the potential for moral hazard where fair use is covered, in that film-makers at the very least might not go the extra mile to acquire a license, or would just take copyrighted material without thinking.⁵¹¹ However, all of them qualified this concern as well.⁵¹²

Paul Paray, formerly of AIG, was conscious of a moral hazard problem and indeed his company had been hit with bad claims once on an

⁵⁰⁶ Lesli Klainberg, Orchard Films, at IFP Fair Use Summit (9/21/07)

⁵⁰⁷ *Id.*

⁵⁰⁸ *Id.*

⁵⁰⁹ Even Eric Brass of public television network GBH, the outlet responsible for producing the majority of documentaries on PBS, and a long-time champion of fair use, believed that while the Statement was valid, even “great,” GBH did not adopt it because of the fourth principle’s contention that historically important copyrighted material may be taken if a license is too expensive or denied for other reasons; he believed this posture was not doctrinally correct. Interview with Eric Brass, GBH-TV, (Sep. 21, 2007).

⁵¹⁰ BLACK’S LAW DICTIONARY 719 (6th ed. 1990).

⁵¹¹ *See, e.g.*, Telephone Interview with Michael Donaldson, *supra* note 73.

⁵¹² *See, e.g.*, Telephone Interview with Michael Donaldson, *supra* note 73.

independent film when a film-maker/insured relied on insurance while surreptitiously not clearing some footage.⁵¹³ Paray said this case did not involve a documentarian, and that he believed non-fiction film-makers operate in good faith and only opt for fair use when they have no other choice.⁵¹⁴ Calling them consistently responsible actors, he made it understood that moral hazard and malicious usage only surfaced in commercial fiction feature films.⁵¹⁵ Michelle Tillton of First Media's worst-case moral hazard scenario is that a documentarian will represent on her application that she received all permissions, a policy will be issued, and then it turns out no permission existed.⁵¹⁶ This scenario remains hypothetical, and given First Media's directive to their insured on having counsel vet the film, it will likely remain unrealized.⁵¹⁷ She also expressed that the danger of loss of the film to injunction would keep film-makers honest, and only extraordinary ignorance and a complete lack of guidance by counsel and insurer could ever allow this to happen.⁵¹⁸

VIII. CONCLUSION: A NEW TYPE OF REGULATORY INSURER, OR A BETTER INSURED?

Before the appearance of the Statement and insurers' subsequent embrace of documentarians' fair use assertions, insurers filled a regulatory vacuum operating on behalf of an owner-friendly copyright regime.⁵¹⁹ As gatekeeper, E & O insurers could deny documentarians from coverage for un-cleared footage, and thus prevent a film from being seen.⁵²⁰ Even where

⁵¹³ Interview with Paul Paray, *supra* note 294.

⁵¹⁴ *Id.*

⁵¹⁵ *Id.*

⁵¹⁶ Telephone Interview with Michelle Tillton, *supra* note 294.

⁵¹⁷ *Id.*

⁵¹⁸ *Id.*

⁵¹⁹ Interview with Anthony Falzone, *supra* note 313.

⁵²⁰ Pat Aufderheide at IFP Summit, Panel Discussion, *supra* note 503.

no per se bar existed, as at AIG, the fair use underwriting process was lengthy, cumbersome, ad hoc, and uncertain.⁵²¹ From the film-makers perspective, all of these factors were aggravated by the process' proximity to the film's acquisition of a distributor, and its potential to delay a films release.⁵²²

Since the appearance of the endorsements and public embrace of fair use by the insurers who do not affirmatively endorse fair use, the E & O insurer still fulfills a regulatory function, but of a different kind.⁵²³ All four insurers require a documentarian asserting fair use to have the film vetted by competent copyright counsel, with an opinion letter stating that the use satisfies the four § 107 factors.⁵²⁴ The insurers may have been persuaded of the validity of fair use,⁵²⁵ but perhaps more importantly, the documentarian/insureds have been compelled by their insurers to use uncleared material in compliance with the doctrine.⁵²⁶ While this comes with the added expense of retaining counsel to vet the film, the reward comes not merely in the form of a more efficient underwriting process and greater certainty of coverage.⁵²⁷ With each opinion letter, each subsequent grant of coverage, and each film released exercising responsible fair use, the doctrine may gradually be incorporated into industry custom and practice. Since, as some theorists argue, custom and practice – “what is reasonable” – lies beneath the often mechanical deployment of the four factors in the courts, an expansion over time of customary fair use in documentary film

⁵²¹ Interview with Debra Kozee, *supra* note 289.

⁵²² Donaldson, *supra* n 188 at 198.

⁵²³ Pat Aufderheide at IFP Summit, Panel Discussion, *supra* note 503.

⁵²⁴ Interview with Paray, *supra* note 294.

⁵²⁵ AIG, in dropping its per se exclusion certainly was; Chubb and First Media maintain they have needed no such persuasion; and Media/Pro, in adopting the pro bono defense promise offered by Stanford Law School litigators, have armed themselves with a weapon that relaxes the need to be a policeman considerably. Interview with Lieb Dodell, *supra* note 282.

⁵²⁶ See Interview with Michelle Tillton, *supra* note 294.

⁵²⁷ See telephone interview with Leib Dodell, *supra* n. 283.

may be dispositive, should the day comes that a case gets litigated. The insurer as “good cop” regulator, granting the “carrot” of coverage of uncleared material by steering his insured towards responsible fair use with the “stick” of retaining counsel is a vicarious educator. Through the demand for an opinion letter, he guarantees that the film-maker will learn the law during the post-production process. Both Michael Donaldson and Anthony Falzone sit over the shoulder of their clients, and make sure that the material taken makes its point, makes it with only as much taking as necessary, and makes it in such a way that it explains itself contextually (not just to the audience, but to a prospective judge as well).⁵²⁸

The insurer and copyright attorney schooling the film-maker are but part of a team of teachers, indeed only the last ones in a line. The events of February 2007 were the results of collective action by the documentary community to solve a collective action problem, and insurance was only a piece of it, even if it was the key piece.⁵²⁹ “Untold Stories” established that film-makers were ignorant of fair use, or, if they knew something about it, were too discouraged by resistance by gatekeepers to exercise it. Since then, an active support system has sprung up, to educate film-makers in their rights and responsibilities with respect to fair use.

Conferences and seminars at documentary events, such as festivals, are a regular occurrence.⁵³⁰ A network of linked electronic resources for film-makers abound, where film-makers, attorneys, and activists can share their knowledge and experience of fair use.⁵³¹ Duke University’s Center for the Study of the Public Domain even offers a fair use comic book, explaining the doctrine and best practices.⁵³² Under the aegis of the Center

⁵²⁸ Interview with Anthony Falzone, *supra* note 313; Telephone Interview with Michael Donaldson, *supra* note 73.

⁵²⁹ See Telephone Interview with Michael Donaldson, *supra* note 73.

⁵³⁰ See, e.g., Center for Social Media at American University, <http://www.centerforsocialmedia.org> (last visited Apr. 14, 2009).

⁵³¹ *Id.*

⁵³² CENTER FOR THE STUDY OF THE PUBLIC DOMAIN, DUKE UNIVERSITY, *TALES FROM THE PUBLIC DOMAIN: BOUND BY LAW?* (2006), available at www.law.duke.edu/cspd/comics/digital.php.

for Social Media, film students can enter their documentary projects for a “Best Fair Use” award.⁵³³ All of this fosters a better, more responsible insured. Michael Donaldson, when called “the hero of the story” because of his victory after decades in the trenches of fair use wars, replied, “No. The film-makers are the heroes.”⁵³⁴ Their progress, from fighting and usually losing isolated battles on the clearance front, to becoming a unified group dedicated to learning the law and then putting it into practice, is what changed the game.⁵³⁵ Insurers, whether they smelled money, good public relations, or always had a genuine sympathy for their insureds, provided the key that un-locked the gate, but it was in large part because of the momentum built by the community.

⁵³³ *April 2008 Newsletter*, CENTER FOR SOC. MEDIA (Am. Univ. Sch. of Commc'ns), available at <http://www.centerforsocialmedia.org/newsletter/entry/2008april/>.

⁵³⁴ Conversation with Michael Donaldson, IFP Fair use Summit, *supra* note 73.

⁵³⁵ **THIS FOOTNOTE HAS NO TEXT.**

**CROP INSURANCE IN THE
AGE OF BIOTECHNOLOGY:
SHOULD FEDERAL CROP INSURANCE
ENDORSE BIOTECHNOLOGY?**

*Steve Cooper**

This casenote discusses whether biotechnology should be endorsed by federal crop insurance. It reviews the history and the goals of the Federal Crop Insurance Corporation, as well as the role that it plays in the American agricultural system. Genetically modified crops are becoming more prominent in U.S. agriculture, yet they have not been addressed by federal crop insurance. The U.S. Department of Agriculture recently established the pilot program Biotech Yield Endorsement, whose goal is to bring together the federal crop insurance system with the growing industry and market for genetically modified seeds. Agricultural policymaking is also reviewed and categorized as economically inefficient. This note argues that a permanent biotechnology endorsement program should not be implemented until it has been proven that the environmental and economic consequences do not make lower crop insurance premiums inadvisable.

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INTRODUCTION

As the wealth of biological and genetic knowledge has improved over the past century, the ability to study and modify the genome of an organism has revolutionized many industries. Agriculture in the U.S. has seen as many changes as any other industry. Over the past several decades, biotechnology has played an increasingly prevalent role in the agriculture industry. For example, in 2001, 26% of corn grown in the United States was genetically engineered.¹ Since then, that number has more than tripled to 80%.² This technology has become so widespread because the ability to engineer a plant resistant to certain pests or weeds allows farmers to increase their yield and profits.

Along with subsidies, the federal crop insurance program has played a major role in allowing the federal government to aid farmers and stabilize the nation's agriculture industry.³ Although the federal crop insurance program has been in place for the past eighty years, it has not been without its shortcomings.⁴ One aspect of agriculture that federal crop insurance has not addressed, despite its prevalence in the 21st century, is genetically modified crops. If a farmer plants seeds that are genetically engineered to reduce the risk of crop loss, then logically, crop insurance premiums should be adjusted according to this reduction of risk. For this reason, in 2007 the Federal Crop Insurance Corporation (FCIC) and Risk Management Agency (RMA), both part of the U.S. Department of Agriculture (USDA), devised the Biotech Yield Endorsement pilot program, which for the first time would lower the premiums paid by farmers who planted specific hybrid seeds created by biotech companies.⁵

¹ Pew Initiative on Food and Biotechnology, Factsheet: Genetically Modified Crops in the United States (Sept. 2004), http://trusts.orgpewagbiotech/news_room_detail.aspx?id=17950.

² Nat'l Agric. Statistical. Serv., U.S. Dept. of Agric., Acreage 24 (2008).

³ Joseph W. Glauber, *Crop Insurance Reconsidered*, 86 AMER. J. AGR. ECON. 1179, 1179 (2004).

⁴ *Id.*

⁵ U.S. Dept. Agric., Pilot Biotech Yield Endorsement Insurance Standards Handbook 2008 and Succeeding Crop Years 1-2 (2007), available at

Despite the apparent merits of encompassing a biotechnology endorsement in the federal crop insurance system, it is uncertain if the endorsement can solve many of the old and lingering problems facing the federal crop insurance program, or if it may in fact create new problems. There are several economic and environmental concerns that are presented by a biotechnology endorsement, rendering the promise and potential of the new policies ambiguous.

Part I of this paper details the history of the federal crop insurance program in the U.S. and examines the goals of this program. Part II explains the recent biotechnology endorsements that have been instituted by the USDA that have reduced crop insurance premiums for farmers who plant seeds generated by biotechnology. Part III examines whether these biotechnology endorsements will have a positive economic impact on the federal crop insurance program. This includes whether the endorsements could result in increased participation in the federal crop insurance program. Part IV, however, discusses how, despite the promise of a biotechnology endorsement, it could be, as similar agricultural legislation has been, problematic both economically and environmentally. Lastly, Part V explains why the specific pilot programs implemented by the USDA and biotechnology endorsements could be generally beneficial as they safely shift federal crop insurance into an age dominated by genetically modified organisms and how these pilot programs can avoid certain pitfalls over the course of their implementation.

I. THE HISTORY AND GOALS OF THE FEDERAL CROP INSURANCE PROGRAM

In order to evaluate the efficacy and potential problems presented by a federal endorsement of biotechnology and hybrid seeds through crop insurance, it is important to examine the role that crop insurance plays in the U.S. agricultural system. This section discusses the purpose and establishment of the federal crop insurance program, how federal crop insurance is administered, and what is necessary for the program to succeed.

A. THE FEDERAL CROP INSURANCE ACT

The Federal Crop Insurance Act (“The Act”) establishes an insurance and reinsurance program whereby the holder of an insurance plan is covered against “losses of the insured commodity... due to drought, flood, or other natural disaster.”⁶ Through the USDA, the federal crop insurance program is administered by the FCIC, a group that is also established by the Act.⁷ For much of the history of federal crop insurance, it was entirely administered by the FCIC, which acted as the primary insurer.⁸ In recent years, however, there has been a shift towards a new system, whereby federal crop insurance is not administered directly by the FCIC. Instead, the FCIC acts as a reinsurer for private insurance providers.⁹ Under this system, the eligibility of private insurance providers and the terms of federal crop insurance policies are subject to approval by the FCIC.¹⁰

The Act was passed in 1938 as part of the New Deal in an attempt to help rejuvenate the state of American agriculture following the Great Depression.¹¹ The stated purpose of the Act is “to promote the national welfare by improving the economic stability of agriculture through a sound system of crop insurance and providing the means for the research and experience helpful in devising and establishing such insurance.”¹² The

⁶ 7 U.S.C. § 1508(a) (2008).

⁷ 7 U.S.C. § 1503 (2008).

⁸ U.S. Gen. Accounting Office, *Crop Insurance: Opportunities Exist to Reduce Government Costs for Private-Sector Delivery* 18-19 (Apr. 1997) [hereinafter U.S. GAO Report].

⁹ Christopher R. Kelley, *The Agricultural Risk Protection Act of 2000: Federal Crop Insurance, The Non-Insured Crop Disaster Assistance Program, and the Domestic Commodity and Other Farm Programs*, 6 DRAKE J. AGRIC. L. 141, 143 (2001).

¹⁰ *Id.*

¹¹ Richard P. Shafer, *Annotation, Construction and Application of Federal Crop Insurance Act*, 185 A.L.R. Fed 419 (2003).

¹² 7 U.S.C.A. § 1502(a) (2008).

Act, however, was unable to establish the prescribed “sound system of crop insurance” as originally stated, resulting in several amendments to the Act in the past century.¹³

A major problem with the originally-devised federal crop insurance scheme was that incomplete and therefore ineffective coverage resulted. Initially, wheat was the only crop insured under the Act and coverage was geographically limited, thus, certain areas of the country were ineligible for coverage.¹⁴ Thus, the program, as it was initially devised, created an insurance system that was more costly than legislators and taxpayers intended. Low participation led to an increase in premiums for the participants and an increase in taxpayer contribution to the program.¹⁵ To remedy the problem, numerous amendments were made to the program in the following decades in order to increase coverage both in terms of included crops and geographical scope.¹⁶ The hope was that these changes would result in a more cost effective insurance program.

B. AMENDMENTS TO THE FEDERAL CROP INSURANCE PROGRAM TO INCREASE PARTICIPATION

Despite recognition that the success of federal crop insurance was dependent upon high participation rates, by 1980, following the attempts to improve the program, crop insurance was still only offered for thirty crops in only one-half of the counties in the United States, and only 10% of the eligible area was insured.¹⁷ Thus, it is not surprising that the USDA was forced to pay out hundreds of millions of dollars in emergency loans during the 1970s.¹⁸ In another attempt to improve federal crop insurance, the

¹³ David F. Rendahl, Comment, *Federal Crop Insurance: Friend or Foe?*, 4 SAN JOAQUIN AGRIC. L. REV. 185, 186 (1994).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* (stating that subsequent amendments to the Federal Crop Insurance Act were enacted four times from 1949 to 1968).

¹⁷ Steffen N. Johnson, *A Regulatory ‘Wasteland’: Defining a Justified Federal Role in Crop Insurance*, 72 N.D. L. REV. 505, 513.

¹⁸ *Id.*

Federal Crop Insurance Improvement Act of 1980 introduced more government subsidies in order to promote the purchasing of insurance.¹⁹ Congress believed that if premiums were at least partially subsidized, farmers would be more willing to participate in the program.²⁰

While these changes did result in an expansion of the availability and participation in the federal crop insurance program, the improvements still resulted in only 25% participation within eligible acreage by 1988, much lower than the 50% participation rate expected by Congress.²¹ Due to the low participation, the federal government was again forced to pass supplemental legislation to account for crop losses occurring from disasters, which reached almost \$5 billion for the years 1988-1989.²² In an effort to continue to reduce these ex post payments, Congress passed the Crop Insurance Reform Act of 1994 to further increase subsidization.²³ In fact, one way the 1994 revisions attempted to avoid making ad hoc payments to uninsured farmers was by trying to remove the legal authority to make such payments for a crop that is covered by the insurance.²⁴

One of the most significant developments resulting from this period of changes was the inclusion of private insurers in the insurance program and an expansion of their role in the system.²⁵ Rather than administer insurance policies directly to producers, the USDA reinsures private groups through the FCIC and the RMA. For the administration of crop insurance policies, private companies that participate in the program

¹⁹ Glauber, *supra* note 3, at 1179.

²⁰ Johnson, *supra* note 17, at 514.

²¹ Glauber, *supra* note 3, at 1179-1180. Coinciding with the increase in participation was an increase in availability of federal crop insurance, as by the end of the 1980s, some form of federal crop insurance could be obtained in all 50 states and the number of insurable commodities increased by 70%. Johnson, *supra* note 17, at 515.

²² Glauber, *supra* note 3, at 1179.

²³ *Id.*

²⁴ Johnson, *supra* note 17, at 519.

²⁵ U.S. GAO, *supra* note 8, at 19.

are paid a fee by the RMA.²⁶ Furthermore, the private company and FCIC share the underwriting gains, as well as the underwriting losses.²⁷ Thus, acting as a reinsurer can be greatly beneficial for the government, as they can share the risks and potential losses of the crop insurance system and avoid much of the responsibility for selling crop insurance programs directly to farmers. As noted, however, by the United States General Accounting Office, the relationship between the federal government and private insurance companies has been an imperfect one, with the federal government remaining responsible for significant losses.²⁸

C. THE AGRICULTURAL RISK PROTECTION ACT OF 2000

Despite a large increase in the number of insured acres in the wake of the 1994 amendments, from 83.7 million in 1993 to 220.5 million in 1995, further legislation was passed in 2000 to address the reductions in participation and additional ex post payments were still required to cover losses, which occurred throughout the later years of the decade.²⁹ The Agricultural Risk Protection Act of 2000 (“A.R.P.A.”) was passed in order to further increase the subsidization of producers, as well as to implement several other new practices.³⁰ Two notable measures were adopted to increase the ability and flexibility of the FCIC to adopt future measures improving federal crop insurance.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *See id.* at 24, 29 (The GAO report details several examples of how the federal government as a reinsurer is still taking on significant financial losses. Between the years of 1990 and 1996, the federal government administered \$2,168,000,000 in reimbursements to private insurers, significantly higher than the \$528,000,000 earned by those private insurers in underwriting gains. Furthermore, the administrative reimbursements made by the government to insurers is often in excess of the administrative expenses of those insurers, thereby leaving the government spending far more money than necessary. The GAO reports this amount to be \$38 million for the years of 1994 and 1995).

²⁹ Glauber, *supra* note 3, at 1179-1181.

³⁰ Kelley, *supra* note 9, at 142-143.

First, the A.R.P.A. provides for increased research and development of new risk management tools.³¹ The FCIC was given the authority to enter into contracts with private or public entities to advance research and development targeting participation levels in federal crop insurance.³² Additional objectives of the new provisions of the A.R.P.A. were to “to allow producers to take preventative actions to increase end product profitability and marketability and to reduce the possibility of crop insurance claims,” “to develop a multifaceted approach to pest management and fertilization to decrease inputs, decrease environmental expose and increase applications efficiency,” and “to develop other risk management tools to further increase economic and production stability.”³³

A second significant inclusion in the A.R.P.A. is the authorization of the FCIC to implement pilot programs.³⁴ The FCIC can develop and conduct pilot programs “to evaluate whether a proposal or new risk management tool tested by the pilot program is suitable for the marketplace and addresses the needs of producers of agricultural commodities.”³⁵ The types of issues that may be addressed through pilot programs vary greatly, ranging from destruction of bees due to the use of pesticides to risks associated with fruits, nuts, vegetables and specialty crops.³⁶ Further, the FCIC may implement programs that provide producers with reduced premiums for using whole farm units or single crop units of insurance.³⁷ The A.R.P.A. specifically prescribes a pilot program whereby approved insurance providers may propose policies with reduced premium rates for one or more agricultural commodities within a limited geographic area.³⁸

³¹ 7 U.S.C. §1522 (2008).

³² 7 U.S.C. §1522(c)-(d) (2008).

³³ 7 U.S.C. §1522(d) (2008).

³⁴ 7 U.S.C. §1523 (2008).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

Despite all of these attempts at improving federal crop insurance, however, many of the problems that have plagued the program still persist. In 2002, the costs of the program had tripled from the costs of 15 years earlier.³⁹ In the same year, Congress was still making supplemental payments in order to recoup losses suffered during that year.⁴⁰ Thus, even though many changes have been made to the federal crop insurance program improving some of the program's shortcomings, there still is a need for more improvements to the program to reduce the cost to taxpayers.

D. WHY DO FARMERS IN THE UNITED STATES NEED FEDERAL CROP INSURANCE?

As evidenced by the effort put into the significant number of amendments and the attempted improvements to federal crop insurance over the past eighty years, and despite persistent problems, there are many justifications for the government creating a successful crop insurance program. A primary reason for a federal crop insurance program is the importance of preventing American farmers from suffering substantial losses that occur due to natural causes, such as weather, and unnatural causes, such as market forces determining crop prices.⁴¹ Prevention of these significant losses is necessary because they could threaten the stability of a part of the American economy as well as of a significant food source.⁴² Government programs, such as federal crop insurance, allow farmers to reduce the cost of production, which subsequently has a positive impact on all Americans, helping to lower the price of food.⁴³

A second justification for federal crop insurance is the inability of the private market to foster such a program.⁴⁴ Insuring crops involves a

³⁹ Glauber, *supra* note 3, at 1180.

⁴⁰ *Id.*

⁴¹ Rendahl, *supra* note 13, at 186.

⁴² *Id.*

⁴³ Galen E. Boerema, Comment, Turning Straw Into Gold: Federal Securitization of Agricultural Commodities, 83 N.C. L. REV. 692-93 (2005).

⁴⁴ U.S. GAO REPORT, *supra* note 8, at 18-19.

high degree of risk due to the unpredictability and high frequency of the types of events that trigger crop losses.⁴⁵ Severe weather, for example, cannot be easily predicted or protected against by farmers and is a factor that will affect a large number of producers. Due to the unpredictable nature of losses insured against, such a program requires a substantial level of participation in order to effectively spread the risk and consequently, the costs.⁴⁶ This feature can be much better addressed with a large, federal system of crop insurance, rather than with a system of individual private companies, each with separate and low participation rates. A further consequence of the unpredictability of the risks involved with crop insurance is the difficulty it creates when deciding on the cost of premiums. In the lead up to the Federal Crop Insurance Act, the inability to determine appropriate premium costs was cited as a significant failure of the privatization of crop insurance and as reason for putting the system under government control.⁴⁷

Finally, as seen in the above discussion of the history of the Federal Crop Insurance Act, because agriculture plays such a large role in stability around the world, major losses will not go uncompensated. Thus, without a high level of participation in some form of crop insurance there will be a persistent need to administer ad hoc payments to farmers to recover for losses that occur due to disasters.⁴⁸ As pointed out by Steffen Johnson, in the 1980s the federal government spent \$19 billion on emergency loans and disaster relief for farmers, more than tripling the expense of federal crop insurance over that same period of time.⁴⁹ Despite

⁴⁵ Johnson, *supra* note 17, at 526.

⁴⁶ *Id.*

⁴⁷ Rendahl, *supra* note 13, at 187. The specific reasons given to President Roosevelt that private companies could not administer crop insurance included: “(1) The insurance was only offered in limited areas that did not sufficiently spread the risk if there was a major crop failure; (2) The private companies tried to cover losses from price declines, as well as crop failures, (3) The companies did not have the capability to properly determine the degree of risk, so premiums were not matched with the risk involved.” *Id.*

⁴⁸ Johnson, *supra* note 17, at 507.

⁴⁹ *Id.* at 515-16.

the increase in participation in crop insurance, however, these expenditures are still prevalent, as in 2002 \$2.1 billion was still spent in disaster assistance to producers.⁵⁰

II. THE BIOTECHNOLOGY ENDORSEMENTS

A. THE BIOTECH YIELD ENDORSEMENT

Beginning in the 2008 crop year, the USDA decided to make an additional attempt at solving the lingering problems of federal crop insurance by taking advantage of many of the mechanisms that were established by earlier legislation, when it began the Biotech Yield Endorsement (BYE). The BYE is a pilot program incorporating a relationship with private industry groups. The program sought to bring together the federal crop insurance system with the growing industry and market for genetically modified seeds. Not an independent creation by the USDA, the BYE came to fruition with the assistance of a prominent force in the industry of genetically modified crops, the Monsanto Company. Following two years of research, Monsanto presented the RMA with their proposal and supporting data.⁵¹ The rationale supporting the program that was presented by Monsanto, and accepted by the USDA, was that if a farmer is planting a biotech hybrid, the farmer is doing so to reduce the risk of crop loss and to increase yield amounts, so it is logical that the crop insurance program should account for this risk-reducing practice.⁵² Thus, for the first time, American farmers in the eligible states of Iowa, Indiana, Illinois and Minnesota benefited, through the federal crop insurance system, for planting seeds containing specific traits developed by the biotechnology industry.⁵³

Since the BYE is a pilot program, which by its nature will be restricted in several ways through the Federal Crop Insurance Act, it is also

⁵⁰ Glauber, *supra* note 3, at 1183.

⁵¹ Peter Shinn, *USDA Approves Unique Biotech Corn Insurance Policy*, BROWNFIELD AG NEWS, Sept. 27, 2007.

⁵² *Id.*

⁵³ BYE HANDBOOK, *supra* note 5, at 1.

limited in several other regards. First, the program did not apply to all agricultural commodities, only non-irrigated corn for grain.⁵⁴ Further, in the unit of corn acreage which is to be insured, it is required that 75 percent of the acreage planted be non-irrigated corn of a qualifying hybrid.⁵⁵

Second, the producer seeking to take advantage of the BYE must also have a certain type of crop insurance policy. In general, there are two categories of coverage that are administered: yield-based and revenue-based.⁵⁶ In yield-based insurance programs, the insurance policy and losses are framed around the amount or value of a producers' total expected yield.⁵⁷ In revenue-based insurance programs, producers insure an amount of expected revenue, rather than yield. Under the BYE, three specific policies are eligible for the program: Actual Production History (APH), Crop Revenue Coverage (CRC), and Revenue Assistance (RA) plans of insurance.⁵⁸

In order to understand how these specific plans function, it is helpful to understand the general model by which federal crop insurance operates. A participant in the program selects an amount of yield or revenue to be guaranteed.⁵⁹ If the production at the end of the harvest results in less than the guaranteed amount, then the insured participant is indemnified for the difference between the production and guarantee, which is calculated in a form dependent upon the insurance plan.⁶⁰

APH policies are yield-based and apply to losses in yield due to the causes permitted by the FCIA.⁶¹ Thus, the indemnity given in the event of

⁵⁴ *Id.* at 4.

⁵⁵ *Id.*

⁵⁶ Kelley, *supra* note 9, at 144.

⁵⁷ *Id.*

⁵⁸ BYE HANDBOOK, *supra* note 5, at Exhibit 2.

⁵⁹ Rendahl, *supra* note 13, at 188-89.

⁶⁰ *Id.* For an example of how a payment is calculated for federal crop insurance. *See id.*

⁶¹ U.S. DEPT. AGRIC., *Crop Policies* <http://www/rma.usda.gov/policies/> (last visited Oct. 15, 2008).

loss is based on the selected amount of average yield insured and the price at which the crop is insured, wherein the average yield can be determined by examining at the insured's historical yield productions.⁶² In contrast, CRC and RA plans are both revenue-based plans. CRC insures revenue by compensating for losses below the guaranteed average gross farm revenue, which is based on the higher of an early season price or harvest price.⁶³ In RA plans, the producer is covered for a pre-selected target revenue typically between 65 and 75 percent of the total expected revenue.⁶⁴

A third limitation in the BYE is that the qualifying hybrids are restricted to those containing combinations of specific traits. As a result of the Monsanto Company's role in developing the BYE, all of the traits that qualify farmers for the premium reduction, YieldGard® Rootworm, YieldGard® Corn Borer, and Roundup Ready® Corn 2, are produced by the company.⁶⁵ YieldGard® Rootworm is designed to protect corn roots from various species of rootworm.⁶⁶ The touted benefits of this feature are increased nutrient uptake from the soil and decreased need for sprayed insecticide.⁶⁷ The second trait, YieldGard® Corn Borer, targets the corn borer insect, which attacks the corn stalk.⁶⁸ It carries with it many of the potential benefits also possessed by YieldGard® Rootworm. The final trait, Roundup Ready, unlike the previous two products, is an herbicide, intended to provide protection from weeds throughout the growing

⁶² *Id.*

⁶³ *Id.*; see also Kelley, *supra* note 9, at 144.

⁶⁴ U.S. DEPT. AGRIC., *supra* note 61.

⁶⁵ BYE HANDBOOK, *supra* note 5, at Exhibit 2.

⁶⁶ Monsanto Company, YieldGard Rootworm, http://www.monsanto.com/monsanto/ag_products/input_traits/products/yieldgard_rootworm.asp#features (last visited Oct. 15, 2008).

⁶⁷ *Id.*

⁶⁸ Monsanto Company, YieldGard Corn Borer, http://www.monsanto.com/monsanto/ag_products/input_traits/products/yieldgard_corn_borer.asp (last visited Oct. 15, 2008).

season.⁶⁹ In order to be eligible for the BYE premium reduction, the hybrid seeds planted by the producer must include one of the aforementioned traits, or a combination thereof. Although they use different mechanisms to achieve their goal, the traits are all designed to increase crop yields.

B. THE PILOT BIOTECHNOLOGY ENDORSEMENT

In August of 2008, however, it was announced that the BYE program would be modified in order to expand the geographic scope of the program, the eligible seed hybrids, and to include specific insurance providers.⁷⁰ Renamed the “Pilot Biotechnology Endorsement”, premium reductions were made available to farmers in Michigan, Missouri, Ohio, South Dakota, Wisconsin, Kansas, and Nebraska, in addition the original four states.⁷¹ The number of participating seed producers also increased, as hybrid seeds produced by Pioneer/Dow AgroSciences, LLC, and Sygenta Seeds, Inc., will also be eligible to those traits manufactured by Monsanto.⁷² Depending on the state and the seed variety, the program also expands coverage for both irrigated and non-irrigated corn.⁷³ Thus, the program that started as a four-year pilot program in only four states will soon see a great expansion as the USDA’s support for biotech hybrid seeds in agriculture continues to grow.

⁶⁹ Monsanto Company, Roundup Ready Corn 2 *available at* http://www.monsanto.com/monsanto/ag_products/input_traits/products/roundup_ready_corn_2.asp.

⁷⁰ U.S. DEPT. AGRIC, FCIC BOARD EXTENDS BIOTECHNOLOGY PILOT COVERAGE AREAS AND QUALIFYING HYBRIDS, (Aug. 18, 2008), *available at* <http://www.rma.usda.gov/news/2008/08/fcicbiotech.html>.

⁷¹ U.S. Dept. Agric., Pilot Biotechnology Endorsement Insurance Standards Handbook 2009 and Succeeding Crop Years 1 (2008) (*available at* <http://www/rma.usda.gov/handbooks/20000/2009/20110.pdf>) [hereinafter Pilot BE Handbook].

⁷² *Id.*

⁷³ *Id.*

III. HOW BIOTECHNOLOGY ENDORSEMENTS CAN IMPACT
DECISION-MAKING IN AGRICULTURE

In order to determine the likely impact on U.S. agriculture of a crop insurance policy that endorses biotechnology based farming, one must first examine whether a program of this nature will effectively alter the habits of American farmers. One way in which the biotechnology endorsements could have an impact is by attempting to increase participation rates in the federal crop insurance program. An additional possible effect of biotechnology endorsements is a shift in seed selection by farmers towards those that carry lower insurance premiums, which in turn could lead to higher crop yields.

As discussed above, it has long been a goal of federal crop insurance reform to increase participation in the program.⁷⁴ Lower participation in the crop insurance program has resulted in increasing program costs.⁷⁵ Thus, one manner in which the success of the biotechnology endorsements can be measured is by the increasing number of farmers who purchase crop insurance associated with the BYE premium reductions.

There is a potential market share of uninsured crop growers who could be influenced by a biotechnology specific insurance plan. As of 2003, federal crop insurance had an eighty percent participation rate, thus leaving one-fifth of farmers uninsured.⁷⁶ In comparison, according to the National Agricultural Statistics Survey in 2008 eighty percent of the corn planted in the United States was of a biotech variety.⁷⁷ Therefore, given the fact that an overwhelming majority of farms are planting biotech crops, it is likely that there is an overlap of these farmers with the 20% of farmers who have not yet purchased insurance. The probability that many of the uninsured farmers in the U.S. are planting genetically modified seeds is high. This group, already utilizing biotechnology generated seeds, may be

⁷⁴ See discussion *infra* Part I.B.

⁷⁵ *Id.*

⁷⁶ Glauber, *supra* note 3, at 1179.

⁷⁷ Nat'l Agric. Statistical. Serv., U.S. Dept. of Agric., Acreage 24 (2008).

induced to buy crop insurance centered around biotechnology premium reductions.

Several factors influence the decision to purchase crop insurance policies. One particular study by Makki and Somwaru found that the most important factors influencing the decision included premium rate, the level of risk, the availability of new revenue insurance products, the level of subsidy, and the design of the contract.⁷⁸ Additional studies have also found many of these factors to be pertinent to the decision to purchase federal crop insurance, in addition to other factors.⁷⁹

The biotechnology endorsements incorporate many of these factors. Most notably, the endorsements will address premium rates. The primary element of the endorsements is to reduce premiums based on the use of the specified products. This directly impacts the cost of federal crop insurance for farmers. By decreasing the premium rate, defined as the total premium cost by total liability, the program positively influences a farmers' decision to participate in federal crop insurance.⁸⁰ Furthermore, given the prominence of biotechnology in agriculture in the U.S., an overwhelming majority of farmers could immediately benefit from this premium reduction.

Additionally, when considering the relationship between the cost of a farmer's premium and the farmer's corresponding risk of loss, the endorsements address a general inequity facing farmers in making their crop insurance decisions. Generally, farmers who are low risk pay higher insurance premiums relative to higher risk insureds.⁸¹ This is because premium prices are determined by the average risk of the entire insurance

⁷⁸ Shiva S. Makki & Agapi Somwaru, Farmers' Participation in Crop Insurance Markets: Creating the Right Incentives, 83 AMER. J. AGR. ECON. 662, 664 (2004).

⁷⁹ See Bruce J. Sherrick et al., *Factors Influencing Farmers' Crop Insurance Decisions*, 86 AMER. J. AGR. ECON. 103, 103 (2004) (citing several studies that have examined factors relating to the purchase of crop insurance and citing as relevant factors: "costs and returns of insurance, yield and other business risks, financial risks, farm size, enterprise and other forms of diversification, coverage levels, and relationships to adverse selection and moral hazard").

⁸⁰ Makki & Somwaru, *supra* note 78, at 663.

⁸¹ *Id.* at 666.

pool, and not targeted to the specific level of risk that farmer carries.⁸² By incorporating both high and low risks into an insurance pool and requiring an average premium, insurance companies are effectively spreading risk and the cost of insuring those risks. Naturally, this creates an entry barrier for low or lower risk farmers to the insurance pool and thus to federal crop insurance programs.⁸³ A solution to that problem is a crop insurance policy that lowers the premium cost on the basis of the nature of the crop. While it may not properly take into account all of the risks that differ between the use of genetically modified crops and non-genetically modified crops, the type of premium rate allocation seen in the endorsements does, to some extent, encourage low-risk farmers to purchase crop insurance.

Despite the fact that the endorsements present several reasons that would seem to increase participation in federal crop insurance, there are other indicators that suggest the opposite could occur, or that no change in participation would result. A second of the factors found relevant by Makki and Somwaru that is addressed by the biotech endorsements is the level of risk.⁸⁴ Biotech crops are designed to increase yield. Accordingly, because of the genetically enhanced traits, there is less risk of loss and consequently, it is less likely that a farmer needs indemnification.

In a study by Sherrick et alia, the attributes of those who do and do not own crop insurance were examined.⁸⁵ The study compared owners of crop insurance policies to those without crop insurance. It found that those without policies believed they would not need indemnity payments for loss in crop yields.⁸⁶ Based on this study, farmers who use biotech crops, and who therefore perceive themselves as low risk, are less inclined to possess, or purchase, crop insurance precisely because of their use of the genetically enhanced crops. The biotech farmer probably has greater confidence that the harvest is less susceptible to external stresses that could potentially

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.* at 663 (The authors measure the “level of risk” by looking at loss frequency and the probability of yield or revenue falling below the guaranteed level).

⁸⁵ Sherrick et al., *supra* note 79.

⁸⁶ *Id.* at 107.

diminish yields. Consequently, by using biotech seeds as a way to reduce the risk of losses, a producer may find it unnecessary to insure against losses.⁸⁷ It has been found that where producers use mechanisms other than crop insurance to reduce the risks of loss, it leads to a reduction in participation in the federal crop insurance program.⁸⁸

On the other hand, this particular finding may also suggest that those who use biotech crops subject to premium reductions will be included among those who are not currently participating in the program. This is because non-participants are less likely to believe they will suffer losses requiring payment; and presumably, biotech crop growers are also less likely than those who do not grow biotech crops to believe they will suffer losses, given the trait enhancements in biotech crops. If it is a goal of the biotechnology endorsements to increase participation in the federal crop insurance program, it is possible that the premium reductions are well-targeted towards a group in need of additional incentives to purchase insurance. Ultimately, whether a non-participant is induced to purchase crop insurance will come down to deciding if the cost of the premium is less than the amount of indemnities that can be expected; therefore, it is logical to lower the premium for a group targeted for potential participation increases.⁸⁹

Furthermore, the Sherrick et alia. study found that those who participated in the federal crop insurance program had higher expected yields than those who did not participate.⁹⁰ One of the general principles supporting the use of genetically modified crops is that it will lead to higher yields because of their crops increased resistance to natural stresses, such as insects, weeds, and weather. Therefore, this seems to indicate that those farmers using biotech crops are more likely to own crop insurance and are thus less likely to be among the non-participants that can be induced by a biotechnology endorsement to purchase federal crop insurance.;

⁸⁷ Glauber, *supra* note 3, at 1180 (discussing why crop insurance participation remained low due to adverse selection and farmers using risk-management strategies).

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Sherrick et al., *supra* note 79, at 107.

With respect to the remaining factors effecting crop insurance purchasing decisions cited by Makki and Somwaru, the endorsements have a less significant impact on incentives for purchasing crop insurance. The endorsements apply to Actual APH, CRC, or RA plans of insurance.⁹¹ None of these three insurance products are completely subsidized, a factor for which consumers of crop insurance have a preference.⁹² However, the availability of revenue-based insurance, as opposed to yield-based insurance, was one of the most prominent factors cited.⁹³

As evidenced by the inquiries into which factors have an impact on a farmers' decision to purchase federal crop insurance, the potential impact a biotechnology endorsement could have on increasing participation is not clear. By lowering the cost of a crop insurance policy, it is likely that the biotechnology endorsements will persuade some to participate in the federal crop insurance program. However, as the studies show, it is not at all clear how many of the twenty percent of uninsured producers will be effected by this decision.

Regardless of the ability of the biotechnology endorsements to persuade non-participants to join the federal crop insurance program, there is another way in which this program could directly impact the affordability of the program. It has been suggested that a farmers' decision of what crop to grow is related to crop insurance policies.⁹⁴ If a crop insurance policy is far more favorable with respect to one crop versus another, the farmer is more likely to plant the crop with the more favorable insurance policy.⁹⁵ If this were to occur as a result of biotechnology endorsements, there could be an increase in the use of genetically modified seeds. The most obvious economic consequence of using genetically modified seeds is increased yields due to decreased crop loss. Accordingly, there would be a diminished need for indemnifications or supplemental payments to be

⁹¹ See discussion *infra supra* Part II.A.

⁹² Makki and Somwaru. *supra* note 78, at 664.

⁹³ *Id.*

⁹⁴ Glauber, *supra* note 3, at 1190.

⁹⁵ *Id.*

given for crop losses.⁹⁶ Thus, by creating a shift to biotech varieties of certain crops, the biotechnology endorsements could reduce the cost of administering the federal crop insurance by reducing the amount of crops that are lost as a result of weather, pests and other factors mitigated by genetically enhanced crops.

IV. THE RELATIONSHIP BETWEEN BIOTECHNOLOGY ENDORSEMENTS IN CROP INSURANCE AND RECENT SHORTCOMINGS IN AGRICULTURAL POLICYMAKING

Although its success has been deemed necessary by both lawmakers and farmers in the U.S., agricultural policymaking is generally deficient in several regards. Many of the policies that are instituted are economically inefficient. In addition, promoting agriculture has often meant that environmental concerns are ignored. This section addresses these issues and how the biotechnology endorsements could follow similar patterns.

A. COMPARING THE BIOTECHNOLOGY ENDORSEMENTS WITH THE ECONOMIC SHORTCOMINGS OF AGRICULTURAL POLICY MAKING

In examining the impact of the biotechnology endorsements, it is worth examining the nature of the relationship between large agricultural corporations, such as those producing the genetically modified seeds at issue, and the farmers who use those products. There has been a shift in U.S. agriculture policy that favors corporate agriculture rather than the contributions of rural farmers.⁹⁷ The cause of this shift lies in several harmful effects from subsidization.

First, corporations receive more funds from the farm bills than smaller farmers.⁹⁸ Subsidization payments, such as those implemented

⁹⁶ Shiva S. Makki et al., *Biotechnology in Agriculture: Implications for Farm-Level Risk Management*, 19 J. AGRIBUSINESS 51, 56-7 (2001).

⁹⁷ Erin Morrow, *Agri-Environmentalism: A Farm Bill for 2007*, 38 TEX. TECH L. REV. 345, 360 (2006). The author further explains how these policies have been devastating to American rural farmers and the notion of the “family farm.” *Id.* at 357-359.

⁹⁸ *Id.* at 369.

under the Farm Security and Rural Investment Act of 2002, are typically tied to the amount and type of commodity produced.⁹⁹ Because of this method of distribution, statistics like those from 1997 illustrate that the largest six percent of farms in the U.S. received 43% percent of the money available for farm support.¹⁰⁰ Furthermore, as Boerema discusses, more profitable farmers receive a greater benefit from subsidization than less profitable farmers who have a greater need for it.¹⁰¹ While profitable farmers are able to keep or spend their subsidies, less profitable farmers are forced to use their subsidies to repay loans, which as a result of poor credit and low profitability carry a much higher interest rate than those for the profitable farmer.¹⁰² As a result, “a federal subsidy can actually accelerate the demise of the very farmers it is intended to protect.”¹⁰³

Second, the use of subsidies has also become an inefficient and ineffective way to improve the status of rural farmers and stabilize agricultural production.¹⁰⁴ Subsidies are administered for specific crop types, which ultimately renders the subsidy ineffective. This is because the subsidized crops lead to immense and unnecessary surpluses of those crops.¹⁰⁵ Rather than help the farmers, farmers have to sell these oversupplied crops at lower prices, which in turn leads to a further need for subsidies and the continuation of this cycle.¹⁰⁶ Thus, even though it is asserted that subsidizing agriculture is necessary in order for U.S. farmers to compete on a global scale, the subsidies have resulted in inefficiencies and have benefited large farmers disproportionately to others.¹⁰⁷

⁹⁹ Boerema, *supra* note 43, at 701-02, 709; Morrow, *supra* note 97, at 370.

¹⁰⁰ Morrow, *supra* note 97, at 370.

¹⁰¹ Boerema, *supra* note 43, at 709.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ See Morrow *supra*, note 97, at 357-360, 369-371.

¹⁰⁵ *Id.* at 359, 370.

¹⁰⁶ *Id.* at 359.

¹⁰⁷ Boerema, *supra* note 43, at 692-93.

Although offering a lower crop insurance premium is by no means equivalent to a subsidy, biotechnology endorsements are in some ways similar to these unsuccessful agricultural policies. In fact, one of the ways Congress attempted to increase participation in the federal crop insurance program during the 1990s was by subsidizing premium payments.¹⁰⁸ Even though this type of subsidization is more beneficial than typical subsidies, it also is a likely contributor to the fact that the cost of federal crop insurance program grew during that decade.¹⁰⁹ Another similarity is that if the crop premium reductions are given for only a few seed varieties and those seed varieties increase in prevalence, it could lead to similar overproduction that arose from subsidization. As stated earlier, crop insurance policies that are far more favorable to one crop in comparison to other crops have been shown to lead farmers towards production of the specified crop.¹¹⁰ Furthermore, the biotechnology endorsements favor one group of farmers over another, as only those who plant biotech varieties will be able to receive the benefits of the programs.

Additionally, if the crop insurance program favors only a few seed varieties from a few producers, it could lead to a similar shift of corporate favoritism. In the first year of the BYE, some farmers were unhappy with the apparent favoritism the program shown toward Monsanto. When the program was announced, the National Farmers Union came out with a special order of business that stated:

WHEREAS, the purpose of the Federal Crop Insurance Program is to provide appropriate and affordable crop insurance to all producers, regardless of size, equipment or technology, THEREFORE, BE IT RESOLVED, National Farmers Union opposes RMA's approval of the pilot program which allows discounts based upon the use of specific crop genetics. The approval of the BYE pilot program is an endorsement by RMA of Monsanto's triple-stack genetically traited corn and it does not take into effect other technologies or Best Management

¹⁰⁸ Glauber, *supra* note 3, at 1182.

¹⁰⁹ *Id.*

¹¹⁰ *See supra* text accompanying notes 94-95.

Practices. THESEFORE, BE IT FURTHER RESOLVED, National Farmers Union calls for an immediate congressional oversight hearings to investigate the continuation of the BYE pilot program and future RMA partnerships with specific companies on crop genetics for federal crop insurance premium discounts.¹¹¹

Thus, there is a tension amongst farmers regarding whether the crop insurance premium reductions are actually intended to favor them or the biotech seed companies. Although the second year of the program will involve seed manufacturers other than Monsanto, and some of the National Farmers Unions fears of lack of competition may be alleviated, the potential for disparately impacting farmers and seed manufacturers, or at least the appearance of such a disparate impact, is a factor that must be taken into account when establishing this type of federal crop insurance program.

B. COMPARING THE BIOTECHNOLOGY ENDORSEMENTS WITH THE ENVIRONMENTAL SHORTCOMINGS OF AGRICULTURAL POLICY MAKING

As genetically modified agricultural products have gained prominence around the world, they have presented a number of environmental concerns. Furthermore, it has been suggested that these crops will cause unforeseen harms to other species in the ecosystem in which they are used.¹¹² For example, it was suggested that a genetically modified crop, such as those covered by the BYE and Pilot Biotechnology Endorsement, that was engineered to protect against crop destroying pests increased mortality in monarch butterfly larvae in comparison to those larvae eating non-modified crops.¹¹³ However, these specific findings have been challenged, and several studies have in fact found the genetically

¹¹¹ National Farmers Union, 2008 Special Order of Business, Risk Management Agency Biotech Yield Endorsement Pilot Program, (2008), available at <http://nfu.org/wp-content/sob-bye.pdf>.

¹¹² Richard Caplan, *The Ongoing Debate Over Terminator Technology*, 19 GEO. INT'L ENVTL. L. REV. 751,765 (2007).

¹¹³ *Id.*

induced toxin was not more toxic to the monarch butterflies.¹¹⁴ Several other environmental consequences have been noted. It has been suggested that these crops will damage soil ecosystems and increase the use of chemicals such as pesticides, which in turn has harmful environmental and health effects.¹¹⁵ An additional problem that could arise from the use of pest and weed resistant varieties of biotech crops, such as those involved in the current biotechnology endorsement, is an increase in resistance by pests and weeds.¹¹⁶ The use of certain biotech crops, over the long-term, has been found to induce resistance in the pests it seeks to prevent from destroying the crops.¹¹⁷ Similar results have been found with certain chemicals created by crops genetically modified for increased resistance against weeds.¹¹⁸ However, accompanying all of these potential environmental threats is an element of doubt as to their probability.¹¹⁹

Another environmental problem is the threat of gene flow from genetically modified crops to wild plants in the surrounding ecosystem. Gene flow occurs when the genetic material from one organism or group of organisms is transferred and incorporated into the genetic material of another group of organisms.¹²⁰ Gene flow is a natural process and is difficult to prevent in plants, as seeds or pollen can travel by many different mechanisms to other plant varieties.¹²¹ If this were to occur with genetically modified plants, it could have severe consequences for the surrounding ecosystems. Wild plants could take on the genetically

¹¹⁴ Andrew W. Torrance, *Intellectual Property and the Third Dimension of GMO Regulation*, 16 KAN. J. L. & PUB. POL'Y 257, 271 (2007).

¹¹⁵ Caplan, *supra* note 112.

¹¹⁶ See David Hunter, et al., *Int'l Env'tl. L & Pol'Y* 1061 (Foundation Press) (3rd ed. 2007).

¹¹⁷ *Id.* at 1062.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 1061.

¹²⁰ Caplan *supra* note 112, at 763.

¹²¹ *Id.*

enhanced traits, making certain plants much weedier or more resistant to natural threats, also reducing biodiversity.¹²² While it is uncertain whether the genetically modified traits, which are specifically designed for agriculture, will persist in wild plant species, gene flow between genetically modified and wild plant species is one of the most significant environmental threats posed by genetically modified crops.¹²³ Not only could this potentially harm the environment by reducing biodiversity and giving normal plants the genetically modified traits, but it also creates a potential liability problem for the farmers originally using the genetically modified crops. If the genetic material were to escape into neighboring farms, it could ruin others crops, leaving the user of the genetically modified crop liable for damages.¹²⁴

The way that the U.S. has addressed these environmental concerns has differed greatly from the regulatory approach of other countries. The U.S. has taken an approach that views the risks of genetically modified organisms with less caution. When the United Nations Conference on Environment and Development met in Brazil in 1992, it created the Rio Declaration on Environment and Development, a set of principles that would guide future international environmental regimes.¹²⁵ Principle 15 of the Rio Declaration sets forth the precautionary approach as the guiding principle in assessing environmental risks, stating that “[i]n order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.”¹²⁶ Thus, even if the potential harms presented by genetically modified organisms (GMO) are not proven with scientific certainty, steps can be taken to prevent those potential harms. The precautionary principle has been incorporated in the Convention on Biological Diversity and the

¹²² *Id.*

¹²³ *Id.* at 764.

¹²⁴ *Id.*

¹²⁵ The United Nations Conference on Environment and Development, *Rio Declaration on Environment and Development*, June 13, 1992, 31 I.L.M. 874.

¹²⁶ *Id.* at 879.

Cartagena Protocol on Biosafety, both of which govern much of the international use of GMOs.¹²⁷

In contrast to the approach of the international community, the U.S. has taken a much different approach to assessing the environmental impact of GMOs.¹²⁸ U.S. regulatory agencies, such as the Food and Drug Administration (FDA) and the USDA, strive for scientific certainty before taking regulatory action regarding GMOs.¹²⁹ This approach allows for fewer restrictions on GMOs in the absence of hard scientific evidence that they cause environmental harms. As the USDA has taken this approach over the years, it has provided for a lesser regulatory burden on biotech crops and some have theorized that this relaxed approach to regulation is inadequate in ensuring products are environmentally safe before they enter the market.¹³⁰ According to some, as a result of the standards exercised by the U.S. in crafting agricultural policy, the environmental concerns presented by farming have not been adequately addressed.¹³¹ The USDA itself admitted the failure of their agricultural procedures, as it released a report in 2005 stating that they had failed to monitor whether biotech crops

¹²⁷ The Preamble of the Convention of Biological Diversity states: "Noting also that where there is a threat of significant reduction or loss of biological diversity, lack of full scientific certainty should not be used as a reason for postponing measures to avoid or minimize such a threat." Convention on Biological Diversity, Jun. 5, 1992, 1762 31 I.L.M. 822. In the Cartagena Protocol on Biosafety there are two inclusions of the precautionary principle. The preamble reaffirms "the precautionary approach contained in Principle 15 of the Rio Declaration." Cartagena Protocol on Biosafety to the Convention on Biological Diversity, Jan. 29, 2000, 39 I.L.M. 1027.. Annex III states, "Lack of scientific knowledge or scientific consensus should not necessarily be interpreted as indicating a particular level of risk, an absence of risk, or an acceptable risk." *Id.* at annex III.

¹²⁸ Jessica McDonald, Note, Precautionary Pioneer Evades Biotech Giant? Beyond the Cartagena Protocol: The EU Offers the World a Model, 8 OR. REV. INT'L L. 157, 164-171.

¹²⁹ *Id.* at 167.

¹³⁰ Emily Marden, Risk and Regulation: U.S. Regulatory Policy on Genetically Modified Food and Agriculture, 44 B.C. L. REV. 733, 767-776 (2003).

¹³¹ Morrow, *supra* note 97, at 362.

were segregated, that during field tests they failed to test for contamination in the surrounding environment, and that they failed to meet shipping, storage, and disposal standards designed to prevent crops that were not approved from being dispersed.¹³² Although the precautionary approach taken by the international community may be considered overly cautious, the U.S. regulatory response to genetically modified organisms has been one in which the potential environmental harms of the organisms are underestimated relative to the international approach.¹³³ But considering the fact the USDA has decided to use federal crop insurance as a way of promoting the use of biotech agriculture, it does not appear that they are easing support of GMOs.

However, others argue that genetically modified crops may actually benefit the environment. The majority of scientists believe that the use of genetically modified agriculture has resulted in a decrease in pesticide use and a shift towards less toxic herbicides.¹³⁴ In turn, this could lead to less water contamination, improved health for farmers, and improved biodiversity.¹³⁵

A different environmental problem would arise from the biotechnology endorsements if they were to result in overproduction of certain biotech crops. As mentioned earlier, subsidies have led to overproduction of certain crops in the past.¹³⁶ Not only is this practice harmful economically, but it also reduces biodiversity and increases chemical use.¹³⁷ Although biotech crops seek to reduce chemical use, biodiversity is an important environmental contributor to agriculture.¹³⁸

¹³² Rebecca Bratspies, *Some Thoughts on the American Approach to Regulating Genetically Modified Organisms*, 16 KAN. J.L. & PUB. POL'Y 393, 415 (2007).

¹³³ See Caplan, *supra* note 112, at 758-68.

¹³⁴ HUNTER, ET AL. *supra* note 116, at 1061.

¹³⁵ *Id.*

¹³⁶ See *supra* text accompanying notes 104-107.

¹³⁷ See Morrow, *supra* note 97, at 362.

¹³⁸ *Id.*

However, as subsidization has shown, when only a few different crops are grown, it will have harmful environmental consequences.¹³⁹ This practice reduces crop variety and biodiversity, which ultimately makes crops more susceptible to harms such as those posed by pests.¹⁴⁰ Further, production of a select number of crops can also lead to poor usage of land and dependence on certain chemicals.¹⁴¹

V. HOW TO ADVANCE FEDERAL CROP INSURANCE IN THE AGE OF BIOTECHNOLOGY

A. THE FEDERAL CROP INSURANCE PROGRAM SHOULD OFFER LOWER PREMIUMS FOR FARMER WHO USE BIOTECH CROPS

There are several significant points to take from the discussion of the federal crop insurance program and the biotechnology endorsements. First, it is an important goal of the federal crop insurance program to increase participation in the program, which in turn should make it more cost effective.¹⁴² Second, although premiums will be reduced for farmers who plant certain crops generated by biotechnology, which are widespread, it is uncertain if a biotechnology endorsement could induce additional participation in the federal crop insurance program.¹⁴³ Finally, in addition to the simple notion that genetically modified crops increase crop yield, there are numerous economic and environmental mistakes that have been made by agriculture policymakers in the past that should be avoided when the biotechnology endorsements are implemented.¹⁴⁴

In light of all of those considerations, the biotechnology endorsement still appears to be a necessary step in beginning the movement towards tailoring crop insurance to biotech crop growers. It does not make

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² See discussion *infra supra* Parts IA-IC.

¹⁴³ See discussion *infra supra* Part III.

¹⁴⁴ See discussion *infra supra* Parts IV.

sense that two individuals, one carrying less risk of loss than another, should contribute the same amount in premiums for federal crop insurance.¹⁴⁵ As is the case with other types of insurance, if one individual is more likely to need an indemnity payment than another person is, then he or she typically should have to pay a higher premium.¹⁴⁶ A biotechnology endorsement could be a step towards shifting the disparate payment scheme of the federal crop insurance program, whereby the farmers with higher risk pay relatively lower premiums compared to those with lower risk.¹⁴⁷ Even if these endorsements are insufficient to lead to a significant increase in participation in the federal crop insurance program, the biotechnology endorsements will at least make crop insurance policies more affordable for eighty percent of U.S. farmers.¹⁴⁸

B. THE CONCERNS TO BE MONITORED IN ADMINISTERING A BIOTECHNOLOGY ENDORSEMENT

Despite the potential for lower premium costs, there are a number of concerns that are brought up by the biotechnology endorsements that can be monitored while carrying out this pilot program in order to avoid these problems in the future. The most notable problem that the new biotechnology endorsements will present is that of adverse selection. As a result of the numerous insurance options and a lack of actuarial information, farmers are able to “adversely select the option that maximizes their net return.”¹⁴⁹ In contrast to more typical forms of insurance, crop insurance needs to have an extensive period of data collection that it can rely on to establish an economically sound program.¹⁵⁰ Because the biotechnology endorsement is a new program, there are not going to be very much actuarial data initially, thus making it more difficult to

¹⁴⁵ Makki and Somwaru, *supra* note 78, at 666.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *See supra* text accompanying note 77.

¹⁴⁹ Glauber, *supra* note 3, at 1184.

¹⁵⁰ *Id.* at 1185.

accurately project yields and proper premium payments in advance. Considering that the FCIC still has difficulty finding proper ways to calculate risks and yields for the non-biotech crops that have always been covered by the federal crop insurance program, it is reasonable to believe that there will be difficulties insuring a commodity for the first time.¹⁵¹

The problem of actuarial soundness and adverse selection becomes more difficult to assess when also considering how widespread the use of biotech crops is and the differences in yield that occur in different regions. The assertion that the use of a biotech crop results in higher yields is not always true, because yields vary from location to location.¹⁵² In some locations, a certain pest may not be a factor in reducing yields.¹⁵³ Thus, a crop that is genetically modified to express one trait may greatly increase survival in one area of the country, but may have little impact in another.¹⁵⁴ All of this information would have to be taken into consideration before applying blanket premium reductions to those who use GMOs, including the ability of each of the many GMOs that can be used. Otherwise, there would still be some producers who are paying a higher premium than those taking on higher risks.

An additional problem posed by biotechnology endorsements that should be examined given the effects of some U.S. agricultural policies is whether or not the lowering of premiums will benefit all farmers, including rural farmers and farmers who do not plant genetically modified seeds. As stated earlier, U.S. agricultural policies have a history of not spreading benefits equally among agriculturalists.¹⁵⁵ On its face, the biotechnology endorsements only help the farmers who plant qualifying biotech seed varieties and the companies who produce those seeds. If this is the case, then small farmers who do not plant these seeds could continue to be marginalized by U.S. agricultural policies.¹⁵⁶

¹⁵¹ *Id.* at 1184-85.

¹⁵² Makki et al., *supra* note 96, at 56.

¹⁵³ *Id.* at 57.

¹⁵⁴ *Id.* at 56.

¹⁵⁵ See discussion *infra supra* Part IV.A.

¹⁵⁶ Morrow, *supra* note 97, at 357-360.

Solving this problem could be difficult, given that the typical solution to aiding struggling farmers is through subsidies, which create problems in their own right.¹⁵⁷ A theoretical worst case scenario that is derived from insurance programs such as the biotechnology endorsements is that non-biotech farmers are over time less competitive with biotech farmers, and are either placed out of business or are forced to join the biotech farmers and buy seeds from biotech companies. While there could be a market of consumers who prefer non-biotech crops to those that have been genetically engineered, the lack of a requirement in the U.S. that goods be labeled as biotech or not makes this difficult.¹⁵⁸

Many of the other risks and increased costs biotech crops bring could be borne by those who do not even use the biotech crops. Makki et alia suggest that in order for growers to maintain their crops status as “non-biotech,” it will require increased management and segregation costs in an agricultural world that becomes more dominated by biotech varieties.¹⁵⁹ These segregation costs are incurred in both transporting and storing the seeds.¹⁶⁰ How federal crop insurance will address this factor, or if it will be able to adequately contemplate this factor, is uncertain.

Another problem that could be created by a biotechnology endorsement is that it could pose a threat to biodiversity. While this problem is hardly new to the field of agriculture, the biotechnology endorsement certainly does not help solve the problem.¹⁶¹ Many of the qualifying hybrids for the program have the same general traits, and in some cases combine the traits into a single hybrid.¹⁶² The consequences of this homogeneity could be severe if the worst case scenario for pest or weed resistance were to occur.

Furthermore, despite the probability that biotech crops would increase crop yields, there are a number of additional economic risks that

¹⁵⁷ *Id.*

¹⁵⁸ Marden, *supra* note 130, at 735.

¹⁵⁹ Makki et al., *supra* note 96, at 57-8.

¹⁶⁰ *Id.*

¹⁶¹ Morrow, *supra* note 97, at 362.

¹⁶² *See supra* text accompany notes 65-69.

they present. First, although yields may increase and overall profits may see a corresponding increase, there are a number of additional costs that go into using genetically-modified crops. Biotech seeds are generally more expensive than natural seeds because of the research and development costs that seed companies seek to make back.¹⁶³ It is also unclear whether or not in certain situations a farmer using a biotech crop variety will need to purchase more chemicals.¹⁶⁴ Although one would think fewer chemicals should be used if the crop is engineered to protect against the same threats, this has not been entirely the case, as many seed companies require a treatment regimen to go with the use of their seeds, which in many cases has increased the use of herbicides.¹⁶⁵ Use of genetically-modified crops also requires farmers to keep a certain percentage of their crops a non-biotech variety, for reasons which will be explained in the next section.¹⁶⁶ This in turn imposes a number of additional costs on farmers, such as the costs of keeping seeds and crops segregated so that the two crop varieties do not mix.¹⁶⁷

If crop insurance is to be revised for biotech crops, the consequences of contaminating neighboring non-biotech crops should also be taken into account. However, this becomes problematic when attempting to accurately project how often this would occur and what the damages of such an occurrence would be. There is little evidence that conclusively indicates the likelihood of such an event, making it difficult to factor into a crop insurance policy. However, if this possibility is not taken into account, farmers who do not use biotech crops could be the ones who suffer, instead of those who do use the biotechnology.

Another complicated factor that would have to be taken into consideration when attempting to establish insurance premiums for biotech

¹⁶³ Makki et al., *supra* note 96 at 55. The authors state that for certain biotech corn crops in 1999, the cost of biotech seeds were 35-50% greater than non-biotech seeds. *Id.*

¹⁶⁴ Hunter, et al. *supra* note 116, at 1061-62.

¹⁶⁵ *Id.* But see Makki et al. *supra* note 96, at 56 (stating that increased use of herbicide-tolerant soybeans has led to a decrease in use of herbicides).

¹⁶⁶ Makki et al., *supra* note 96, at 57.

¹⁶⁷ *Id.* at 58.

crops is how to account for those who switch from biotech varieties to non-biotech varieties, or vice versa.¹⁶⁸ As explained above, one of the main factors in establishing insurance premiums for some types of insurance, including those included in the BYE and Pilot Biotechnology Endorsement, base the amount of coverage on the farmer's yield history.¹⁶⁹ This creates an inherent problem when a farmer who formerly used a non-biotech seed variety begins using biotech varieties, as such farmers would be offered yield contracts which guarantee payments for yield levels based on previous non-biotech variety yields. In this case, farmers may find the expected value of such a contract to be lower than their willingness to pay for the contracts. Furthermore, the increased yield differentials can alter farms' risk classification, which increases the cost of insurance to biotech crop producers.¹⁷⁰

If the problem in this case is caused by a wide differential between annual yields, it can then be inferred that this problem could arise not only when shifting from non-biotech to biotech varieties, but also when there is a switch from one biotech variety to another that is more effective at increasing yield.

The final element that makes the biotechnology endorsements difficult to administer is the problem of moral hazard. Moral hazard "is the susceptibility of actual yields to the influence of producer actions...or inactions," making it difficult to determine the reason for a farmers yield reduction.¹⁷¹ Seed producers often have a variety of additional instructions that must be followed when planting biotech crops.¹⁷² The increase in procedures also present increased options for a farmer to not follow the procedures, leading to crop losses from a cause that crop insurance is not intended to cover. Therefore, in order to avoid making payments for crop losses that are "voluntary," there would have to be increased supervision of

¹⁶⁸ *Id.* at 61-62.

¹⁶⁹ *See supra* text accompany notes 56-58.

¹⁷⁰ Makki et al., *supra* note 96, at 62.

¹⁷¹ Johnson, *supra* note 17, at 529.

¹⁷² *See supra* text accompanying note 164.

the practices of the farmers who are participating in the biotechnology endorsements.¹⁷³

Therefore, while the biotechnology endorsement is a beneficial model for the federal crop insurance program with respect to improving the insurance premiums of the farmers who plant genetically modified seeds, it is not a perfect model. Because of the number of different factors that could play into the implementation of such a crop insurance program, it is crucial that the biotechnology endorsements serve as tools for monitoring the pros and cons of lowering crop insurance premiums for biotech crops. If this program, and future programs established by the FCIC are created for the primary benefit of corporate agriculture without an eye to the impact on rural farmers and the environment, then the consequences will be severe enough to outweigh the insurance premium savings.

C. THE BENEFITS OF USDA PILOT PROGRAMS SERVING AS A MODEL FOR BIOTECHNOLOGY ENDORSEMENTS

The current pilot program system implemented by the USDA should serve as a beneficial way of phasing in lower premiums for biotech crops for several reasons. The first attribute of the current biotechnology endorsements that makes it a good model for beginning to phase biotech crops into the federal crop insurance program is its status as a pilot program. This is beneficial in several regards. First, it is not a permanent program, but it only will last until 2011, pursuant to statutory prohibitions on a pilot program lasting more than four years.¹⁷⁴ Because the program is unprecedented and because there are a number of questions and doubts about some of the impacts of the program, it is important that a permanent program is not established prior to obtaining more knowledge about the impact of such a program. If it is proven that after a period of time, the environmental consequences of increased use in biotech crops or the economic consequences of endorsing specific agricultural products make lower crop insurance premiums for biotech crops inadvisable, the program

¹⁷³ Johnson, *supra* note 17, at 529.

¹⁷⁴ BYE HANDBOOK, *supra* note 5, at 1; 7 U.S.C.A. § 1523(a)(4)(B) (2008). However, the program can be extended beyond that date or cancelled earlier than that date by the FCIC. 7 U.S.C. § 1523(a)(4)(C) (2008).

can be cancelled and the previous federal crop insurance programs can be reinstated.

Additionally, as can be seen by the transition from the 2008 to 2009 growing seasons, the current structure of the biotechnology endorsements has allowed for reviewing of the program in order to determine how it can be improved. For example, one of the weaknesses of the first year of the program was that only a few seed varieties produced by Monsanto were covered. Although the reason for only including these seeds could be justified (as Monsanto was the only company that had contributed data that their seeds would increase yield,) by only incorporating this one company in the process, it presents the appearance of favoritism and, if the program were to be successful in influencing farmers' choices in seed selection, would give Monsanto a huge advantage over their competitors. However, because the program is constantly reviewed and closely scrutinized by the USDA, after the first year, this deficiency could be improved by covering the seeds of other companies. It is in this fashion that similar improvements can be made from year to year based on the problems that are observed. Because the program includes a great deal of monitoring of the farmers who participate, there is great potential to find weaknesses in the coverage or consequences of using the biotech crops that can be taken into account with future crop insurance policy decisions.¹⁷⁵

Although the future of the federal crop insurance program is far from clear, what does appear to be certain is that crops generated by biotechnology have become a significant part of U.S. agriculture and will continue to grow. In order for the federal crop insurance program to remain relevant and actuarially sound, it will have to accommodate these changes in farming practices coinciding with changes in technologies. By implementing pilot programs that exercise caution as premiums begin to be reduced for biotech crops, the USDA has established a system where they can monitor the impacts of the new policies and hopefully avoid the pitfalls of previous crop insurance regimes and agricultural policies.

¹⁷⁵ See *BYE HANDBOOK*, *supra* note 5, at 27-37 for a discussion of spot-checks of randomly selected policies.

RACE BASED UNDERWRITING AND THE DEATH OF BURIAL INSURANCE

*J. Gabriel McGlamery**

This casenote explores the reasons why industrial life insurance, and the use of racial discrimination, died. The history, as well as the problems presented by industrial life insurance, including discriminatory practices, is reviewed. The 2005 case, Guidry v. Pellerin Life Insurance Company, although a minor suit, is the only industrial life insurance case to offer a holding in regard to the use of race in industrial life insurance. Although the Guidry court held that no rule, law, or statute prevents a life insurance company from using race as a criterion in underwriting life insurance, it can be described as a provocative artifact since industrial life insurance has effectively died. The theories examined include the adoption of legislation that bars the use of race in underwriting life insurance premiums, social pressure to stop using race as a tool in underwriting, and other theories, including the closing of the racial mortality gap, and the success of group life insurance. This note concludes that not one theory on its own is satisfactory, but taken together as a whole they provide some understanding of why industrial life insurance died.

I. INTRODUCTION

Recently, a Louisiana federal district court came to the remarkable conclusion that there was no rule, law, or statute that prevents a life

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insurance company from using race as a criterion in underwriting life insurance.¹ The case, *Guidry v. Pellerin Life Insurance Company*,² was a minor case that came at the tail end of a wave of class action litigation against life insurance companies that had offered industrial life insurance to African-Americans.³ *Guidry* was remarkable only because it actually reached the merits rather than settling or failing on statute of limitation and class certification issues.⁴

The reason why this little case did not cause more than a ripple in the insurance world was because industrial life insurance effectively died almost thirty years ago.⁵ So, the case is more relevant as a provocative artifact than as an influential decision. But, as a provocative opinion it raises questions. First, was the *Guidry* holding correct? Briefly, yes it was. The way the law looks today, in the state of Louisiana, nothing stopped the insurer from doing what it was doing.⁶ It becomes more complex if you widen the holding of *Guidry* to other states and jurisdictions.

¹ *Guidry v. Pellerin Life Ins. Co.*, 364 F. Supp. 2d 592, 599 (W.D. La. 2005).

² *Id.*

³ *E.g.*, *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311 (4th Cir. 2006); *In re Monumental Life Ins. Co.*, 365 F.3d 408 (5th Cir. 2004); *Moore v. Liberty Nat'l Life Ins. Co.*, 267 F.3d 1209 (11th Cir. 2001); *Williams v. Nat'l Sec. Ins. Co.*, 237 F.R.D. 685 (M.D. Ala. 2006); *Norflet v. John Hancock Fin. Servs., Inc.*, 422 F. Supp. 2d 346 (D. Conn. 2006); *Hunter v. Am. Gen. Life & Acc. Ins. Co.*, 384 F. Supp. 2d 888 (D.S.C. 2005); *Carnegie v. Mut. Savs. Life Ins. Co.*, No. Civ. A. CV-99S3292NE, 2004 WL 3715446, at *1 (N.D. Ala. Nov. 23, 2004); *Brown v. Am. Capital Ins. Co.*, No. Civ. A. 01-2079, 2004 WL 2375796 (E.D. La. Oct. 21, 2004); *Thompson v. Metro. Life Ins. Co.*, 149 F. Supp. 2d 38 (S.D.N.Y. 2001).

⁴ *See infra* pp. 14-18.

⁵ See appendix for a chart showing the decline in industrial life insurance. All charts in the appendix are taken from information in the Life Insurance Fact Books. INSTITUTE OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK 30 (eds. 1954-99). As of 2006, industrial life insurance premiums accounted for less than 0.1% of the life insurance market with \$239.6 million in premiums written. *Insurance Information Institute, Facts and Statistics: The Life/Health Insurance Industry*, www.iii.org/media/facts/statsbyissue/life/ (last visited Feb. 10, 2008).

⁶ *See Guidry*, 364 F. Supp. 2d at 592.

Second, if, according to *Guidry*,⁷ the industrial life insurance industry did not stop using race as a factor in pricing because of legislation, why did they stop? Industrial life insurance was inexorably linked to racial discrimination, to cut off the availability of racial discrimination as a tool for underwriting crippled the product. In this paper I will look at a mix of theories as to why industrial life insurance, and the use of racial discrimination, died when it did. The theories I examine are (1) legislative and judicial influence, (2) social pressure, and (3) other forces, such as competition from non-discriminatory insurance products and the drop in the mortality gap between African-American and white policyholders.

In the first section of my paper, I will briefly describe industrial life insurance, its history and the discriminatory practices that came to light in the recent litigation. In the second part I will examine the legislative action, or lack thereof, that may have lead to the death of industrial life insurance. The third part of my paper will discuss the theory that social pressure changed the way the insurance industry used race in underwriting life insurance. The fourth part of my paper will discuss the influence of the decline in the mortality gap between African-American and white policyholders, and the rise of group life insurance. Finally, in the conclusion I will discuss how all of these factors drove the cost of industrial life insurance, and the use of race in underwriting up, past the point where it could survive on the market.

II. A HISTORY OF INDUSTRIAL LIFE INSURANCE

A. WHAT IS INDUSTRIAL LIFE INSURANCE?

Originally named after the industrial workers to whom it was marketed,⁸ it is distinguished by its small premiums, the small face value of its policies,⁹ and the fact that it was usually collected by hand.¹⁰ An agent

⁷ *Id.*

⁸ David A. Ivry, *Historical Development of Some Basic Life Insurance Terminology*, 28 J. INS., Sept. 1961, at 65, 67-68. At the time, the insurance was provided to industrial workers. *Id.*

⁹ The cost and coverage of industrial life insurance has varied from \$25 when it was first offered in America to around \$2,000 toward the end of its existence. MARQUIS JAMES, *THE METROPOLITAN LIFE: A STUDY IN BUSINESS GROWTH* 75 (The Viking Press 1947) (Metropolitan first offered industrial life insurance with benefits from \$25 to \$1,000); Note, *Cost and Coverage of Industrial Life*

of the insurance company would travel door-to-door along a weekly or monthly route, sometimes called a “debt,” to collect the premiums from the policyholders.¹¹ The logic behind the product was that the working poor that needed inexpensive insurance would not be able to budget effectively enough to pay on the quarterly basis, or afford the minimum level of benefits that ordinary life insurance demands.¹² Personal collection was used because mailing was not cost effective and, theoretically, the policyholder did not have the time or motivation to deliver their payments themselves.¹³

However, because of the high overhead costs, the ratio of premiums to the policy’s face value was horrible for all industrial life insurance,¹⁴ and it got much worse if the policyholder was a high risk.¹⁵

Industrial life insurance was sometimes referred to as “debt insurance” after the route the agents would take to collect their premiums.¹⁶

Insurance, 61 YALE L.J. 46, 46 (1952) (\$300); INSTITUTE OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK 30 (1962) (\$1,000); INSTITUTE OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK 30 (1979); *In re Monumental*, 365 F.3d 408, 412 n.3 (less than \$2,000).

¹⁰ *Monumental*, 365 F.3d at 412.

¹¹ *Id.* See Alan Gurganus’s story, *Blessed Assurance*, in his collection, WHITE PEOPLE (1991) for a personal story of a former premium collector.

¹² ALEXA BENSON HENDERSON, ATLANTA LIFE INSURANCE COMPANY: GUARDIAN OF BLACK ECONOMIC DIGNITY 15 (The University of Alabama Press 1990).

¹³ MALVIN E. DAVIS, INDUSTRIAL LIFE INSURANCE IN THE UNITED STATES 7 (McGraw-Hill Book Co., Inc. 1944).

¹⁴ Note, *supra* note 9, at 49. The cost may be attributed to the high mortality of the policyholders and the high operating costs. *Id.*

¹⁵ See *Thompson*, 149 F. Supp. 2d at 46-47. The plaintiff in *Thompson* spent 10¢ a week (\$5.20 per year) for 30 years for a “substandard” life insurance policy. By the end of the period he had paid \$156 for a policy with a face value of \$178. *Id.* A “standard” policy with a face value of \$178 would have cost him \$112 over the same period, while an ordinary (not industrial) life insurance policy would have cost \$81.80. *Id.*

It was also referred to as “burial insurance” when it was marketed as a way for poor people to afford a large funeral.¹⁷ It would pay its small sum soon after the death of the policyholder, sometimes arranging the funeral for the decedent.¹⁸

1. *What Was Wrong With Industrial Life Insurance*

Industrial life insurance has been criticized since its inception because of its deceptively low value, its high overhead, its incredibly high lapse rate, its possible connection to infanticide, and even whether such arrangements benefited the working class at all.¹⁹ Official inquiries have been made into the fairness of industrial life insurance on these grounds throughout its existence.²⁰ However, the evil this note, and the recent wave

¹⁶ The agent collecting the premiums was assigned a fixed area that was referred to as a “debit.” DAVIS, *supra* note 13, at 7. The agents were paid roughly 15% of the premiums they collected on their route. EARL CHAPLIN MAY & WILL OURSLER, *THE PRUDENTIAL* 81-82 (Doubleday & Co., Inc. 1950). See also 1 U.S. Comm’n on Civil Rights, *Discussion by Gayle Lewis-Carter, Special Assistant to the Insurance Commissioner of Pennsylvania in DISCRIMINATION AGAINST MINORITIES AND WOMEN IN PENSIONS AND HEALTH LIFE AND DISABILITY INSURANCE*, 197, 199 (1978) [hereinafter *DISCRIMINATION AGAINST MINORITIES*].

¹⁷ MAY & OURSLER, *supra* note 16, at 32-33.

¹⁸ LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* § 1:42 (3d ed. 2007); DISCUSSION BY ELEANOR LEWIS, ASSISTANT COMMISSIONER OF INSURANCE, STATE OF NEW JERSEY *in DISCRIMINATION AGAINST MINORITIES*, *supra* note 16, at 193. See DAVIS, *supra* note 13, at 189 for a description of the prompt payment, low levels of investigation in industrial life insurance, and marketing the insurance based on the consumer’s need to pay for their funeral.

¹⁹ See generally, DERMOT MORRAH, *A HISTORY OF INDUSTRIAL LIFE ASSURANCE*, 172 (George Allen & Unwin Ltd. 1955).

²⁰ See, e.g., JAMES, *supra* note 9, at 332-33. In 1936 the New York department of insurance examined Metropolitan’s sale of industrial life insurance and found that the high cost of the insurance was justified, but the lapse rate was too high, and the volume of insurance being written on children was questionable. *Id.* See also *DISCRIMINATION AGAINST MINORITIES*, *supra* note 16, at 194-200 (mentioning the poor rate of return on industrial life insurance policies, their unfair claims practices, and mentioning that no insurance at all may be a better option for

of litigation focuses on is industrial life's connection and reliance on racial discrimination.²¹

Because of the need to keep the premiums low despite high overhead costs, the policyholders were rarely given the full medical examination that an ordinary life insurance policy would merit.²² Instead the industrial policies would be issued on the soliciting agents observations and recommendations as well as the applicant's own statements about their health.²³ Because these proxies were used in place of medical examinations, African-American customers were either steered into low paying industrial life insurance policies rather than ordinary policies (the "dual-plan" practice), or the mortality tables were racially segregated ("dual-rate" policies).

Not to condone the practices of the industrial insurers, but it is important to note that the actual mortality rate of African-American policyholders at the time was disturbingly high, and may correspond to the

industrial life insurance policyholders). The assistant to the commissioner of insurance in Pennsylvania mentions attempts to deal with industrial life insurance while it was still a problem by using the unfair trade practices act. *Id.* at 199-200. Their efforts were frustrated by policyholder's distrust of government bureaucracy and their fear of testifying. *Id.* at 199. The industry also tends to write a check and settle the problems of anyone who is vocal enough to cause a problem. *Id.* In 1978, an article in *Consumer Reports* was often cited in the modern cases as evidence of mainstream society's awareness of some of the problems with industrial life insurance. *Insurance that Preys on the Poor*, CONSUMER REPORTS, Nov. 1978, at 661 (calling for a ban of industrial life insurance). See generally MAURICE TAYLOR, THE SOCIAL COST OF INDUSTRIAL INSURANCE (1934).

²¹ DAVIS, *supra* note 13, at 107 ("The race of the applicant also has an important bearing on prospective longevity. Nonwhite races have been found to have a much higher mortality than white persons, which should be considered in underwriting.").

²² Note, *supra* note 9, at 47. "Medical examination of applicants was at best a hasty look-over by a physician who received fifty cents a head for his services." JAMES, *supra* note 9, at 86.

²³ *Id.* If the policyholder died within a year or two their death would be looked into and the "sound health" clause may be used to contest their claim. *Id.* at 58.

high rates charged by the insurers.²⁴ The actions on the part of the insurers seem to be, at least from the record, motivated by a legitimate fear of the high correlation of risk and race in the first half of the twentieth century,²⁵ rather than out of racial animosity.²⁶

²⁴ An investigation into the mortality rates of African-Americans in 1942 by the insurance commissioner of New York found that the mortality rate for African-Americans with ordinary policies was 50% higher than white policyholders. DAVIS, *supra* note 10, at 112. For African-Americans with industrial life insurance policies, owing to different age distributions and different socioeconomic status the rate was 83% higher than white policyholders. *Id.* See also the Appendix for charts showing the mortality gap between white and non-white Americans. The charts used the INSTITUTE OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK (eds. 1954-99).

²⁵ See JAMES, *supra* note 9, at 86-87. In the 1870's the mortality gap between white and African-American policyholders first became an issue. Major companies entering the industrial market such as Prudential and Metropolitan first offered industrial life insurance without using race as an underwriting characteristic. *Id.* By 1881 both companies realized the significance in the mortality difference between the two groups and raised their premiums. *Id.* When states made laws prohibiting discriminatory premiums Prudential stopped selling any insurance to African-Americans in those states while Metropolitan heightened the requirements for African-American applicants. *Id.* In 1907 new industrial life tables were produced that showed the considerable difference in mortality. *Id.* at 551. Both companies reacted by instituting dual-rates and dual-plan practices discussed *infra* pp. 6-9. See also Thompson, 149 F. Supp. 2d 38 at 46-47.

Many studies have been made with respect to the mortality among negroes and all have shown that, class for class, their mortality is higher than that of white persons. It is not true, of course, that all Negroes have higher mortality than any white persons because Negro physicians would undoubtedly show up better than white underground miners. The important fact that needs to be emphasized is that Negroes have higher mortality than white persons of the corresponding class.

Id.

²⁶ See WILLIAMSON & SMALLY, NORTHWESTERN MUTUAL LIFE: A CENTURY OF TRUSTEESHIP, IN DISCRIMINATION AGAINST MINORITIES, *supra* note 16, at 550.

From time to time Northwestern insured the lives of Negroes. In 1885 the problem of getting a full medical history on Negro

While the largest sellers of industrial life insurance were some of the largest insurance companies in the market, it would be a mistake to see industrial life insurance as only a dynamic of large white businesses against poor African-American policyholders. Industrial insurance laid the groundwork that allowed several African-American owned and controlled insurance companies to enter the insurance market.²⁷ Oddly enough, the desegregation of life insurance, both in its sales practices and in its hiring, lead to increased competition with large “white” life insurance companies and the death of industrial life insurance was actually the nail in the coffin of some of the African-American owned companies.²⁸

a. Dual-Rates

“Dual-rate” is the term used for charging African-Americans higher rates for the same benefits as white policyholders.²⁹ Insurance underwriters used to use two separate tables to predict mortality, one for white policyholders, and another for “non-white” policyholders.³⁰ The

applicants raised the question as to the advisability of continuing this practice. Kimball made it clear, however, that “we have no prejudice against insuring colored men growing out of mere fact of color.”

Id.

²⁷ See ROBERT E. WEEMS, JR., *BLACK BUSINESS IN THE BLACK METROPOLIS* 1-26, 29 (Indiana University Press 1996); HENDERSON, *supra* note 12, at 15-19; WALTER B. WEARE, *BLACK BUSINESS IN THE NEW SOUTH* 14-15 (University of Illinois Press 1973).

²⁸ WEEMS, *supra* note 27, at 115-18. In the early eighties, following criticism of industrial life insurance and after the large “white” insurance companies had already stopped offering industrial life insurance, many of the African-American owned companies attempted to follow suit. *Id.* Of the six largest African-American insurance companies, only three, North Carolina Mutual, Atlanta Life, and Golden State Mutual, survived. *Id.* at 115-22.

²⁹ *In re Monumental Life Ins. Co.*, 343 F.3d 331, 336. (5th Cir. 2003).

³⁰ *Id.* (“Liberty national employed the term ‘standard rates’ to refer to insurance rates applicable to African-Americans and the term ‘premium rates’ to refer to insurance rates available only to white individuals.”).

insurance agent would be asked to mark the race of the policyholder, and their premiums would be adjusted accordingly.³¹

Following the industry's abandonment of dual-rates, companies merged the two rate tables,³² or changed the title of the rate tables, but little else.³³ Companies that had an African-American market suffered the most from their inability to separate rates by race.³⁴

b. Dual-Plans

"Dual-plan" practices refer to the various means insurance companies used to steer African-American applicants into discriminatory plans.³⁵ This tactic was often adopted when states or insurance commissioners banned or pressured insurance companies into using race-neutral rate tables.³⁶ Generally, the insurer would offer two tiers of

³¹ DAVIS, *supra* note 13, at 107; *In re Monumental*, 365 F.3d at 412 n.4. The actual difference in the rate structure varies radically amongst plans, but a variety of discriminatory plans were apparent in the cases. For example, in *Monumental* an ANICO rate book from 1962 with an industrial policy for a twenty year old with a face value of \$500 had a weekly premium of \$0.41 while a white policyholder would pay \$0.32. *Id.*

³² *E.g., Thorn.*, 445 F.3d 311, 315.

³³ *See infra* pp. 9-11.

³⁴ DISCRIMINATION AGAINST MINORITIES, *supra* note 16, at 590-91. While companies with a predominantly white market could shift their merged rates toward their white rates, companies with a primarily African-American market had to shift their rates toward the higher mortality of their "non-white" rates or face insolvency. *Id.* at 591. This rate was non-competitive so these companies continued to be restricted to African-American markets. *Id.* Unfortunately, many of the companies that had focused on the African-American market were also African-American owned, and suffered from competition for both applicants as well as personnel. HENDERSON, *supra* note 12, at 191-95.

³⁵ *See* text accompanying note 3.

³⁶ *Thompson v. Metro. Life Ins. Co.*, 149 F. Supp. 2d 38, 47 (S.D.N.Y. 2001) ("Since the laws of several states do not permit us to take race into account in appraising an applicant for insurance, we have had to adopt other means of

industrial life insurance, sometimes referred to as standard plans and sub-standard plans.³⁷ This is where the term “dual-plan” originates. While the plans would be facially race neutral and their rate tables would be approved or created by the insurance commission, there would be an understanding that the tables were made from data specifically gathered from African-Americans and would reflect their particular mortality rates.³⁸

The insurance companies used direct and indirect methods of steering African-Americans into the sub-standard policies. A common practice was to pay agents no commission,³⁹ or only partial commissions⁴⁰

avoiding unfair discrimination against white policyholders in the cost of their insurance.”).

³⁷ See *id.* at 46-47 (using standard and substandard tables); *Carnegie v. Mut. Savs. Life Ins. Co.*, No. Civ. A. CV-99S3292NE, 2004 WL 3715446, at *1 (N.D. Ala. Nov. 23, 2004). Mutual Savings Life Insurance Company divided their policies into “colored cash,” “white cash,” “colored burial,” and “white burial” where the only underwriting factor differentiating between the “white” and “colored” policies was race, as determined by the agent. *Carnegie*, 2004 WL 3715446, at *1. In the 1960’s they stopped calling the bad policies “colored,” but the tables were not changed, with the same S for standard, and R for substandard policies using occupational proxies for race. *Id.* at *2.

³⁸ See *Brown v. Am. Capital Ins. Co.*, No. Civ. A. 01-2079, 2004 WL 2375796, *2 (E.D. La. Oct. 21, 2004), explaining that in New York there was no specified standard mortality table for “substandard” policies, and the tables that the insurance commissioner approved did not explicitly segregate by race. It was “commonly accepted that the [Commissioners Standard Industrial Mortality Table] was created using ‘the experience of white risks’ and the [Commissioners Substandard Industrial Mortality Table] was ‘created using African-American risks.’” *Id.*

³⁹ *Norflet v. John Hancock Fin. Servs., Inc.*, 422 F. Supp. 2d 346, 349 (D. Conn. 2006). The plaintiffs were described as “white” on the application so that the agent could collect his entire commission for selling them standard, rather than substandard policies. *Norflet v. John Hancock Life Ins. Co.*, Civ. No. 3:04cv1099 (JBA), 2007 WL 2668936, *2 (D. Conn., Sept. 6, 2007). On a subsequent application John Hancock corrected this. Memoranda within John Hancock discussed the use of the no-commission policy, excepting sales in New York to avoid anti-discrimination laws. *Id.*

⁴⁰ *Thompson*, 149 F. Supp. 2d at 43 (80% reduction in commissions to offset the mortality risk); *Brown*, 2004 WL 2375796, at *2 n.7 (MetLife only paid their

if they sold standard policies African-Americans, but they allowed full commissions if they sold substandard policies to minorities.⁴¹ Driving down the incentive to sell reasonably priced policies was used as a crude underwriting technique.⁴²

Some insurance companies created a system to steer African-Americans towards substandard policies based on their occupations.⁴³ Under this point system, certain jobs had a greater number of points than others.⁴⁴ The jobs that were selected were manual labor jobs, commonly held by African-Americans in the pre-civil rights era south.⁴⁵

Like the discriminatory use of redlining in homeowners insurance, some insurers would map out the racial ratios of neighborhoods in order to

agents when African-Americans bought substandard insurance); *Norfleet*, 2007 WL 2668936, at *2 (a memo altered John Hancock's "no-commission" policy for African-American policyholders in New York in order to conform to New York laws. They justified their discriminatory steering and commissions because they had a "unitary rate" for their policies and did not use racially based rate tables.).

⁴¹ *Thompson*, 149 F. Supp. 2d at 43.

⁴² *Id.*

⁴³ *E.g.*, *Brown*, 2004 WL 2375796, at *2 n.7.

⁴⁴ *Thompson*, 149 F. Supp. 2d at 44.

⁴⁵ Friedman Decl. Ex. M, *Thompson*, 149 F. Supp. 2d at 44. From a 1945 memo, "Re: Underwriting Negro Lives":

Lowering the underwriting limit for standard Industrial insurance from 200% to 150% of standard Ordinary mortality. Since a materially higher proportion of negro lives would be in occupations rates more than +50 and since a higher proportion of negro lives would also be rated more than +50 for reasons other than occupation, the effect of drawing the limit for standard Industrial insurance at 150% would result in considerably more negro lives than white lives being assigned to the substandard Industrial classification.

Id.

determine the risk associated with that area.⁴⁶ In some cases, different applications would be used in those neighborhoods.⁴⁷ These applications, and the agents providing them, would ask questions about the morals, environment, and habits of the policyholder that were considered “too detailed and otherwise unsuitable” for the standard applications.⁴⁸ The

⁴⁶ *Moore v. Liberty Nat'l Ins. Co.*, 108 F. Supp. 2d 1266, 1270-71 (N.D. Ala. 2000) (“Liberty National, after ceasing to make explicit, race-based distinctions among individuals in setting policy rates, nonetheless continued to sell racially-discriminatory policies by including in the calculation of policy rates factors often directly correlated with race, such as employment in certain occupations or residence in ‘undesirable’ neighborhoods.”); *Brown*, 2004 WL 2375796, at *2 n.7.

⁴⁷ *Thompson*, 149 F. Supp. 2d at 45.

⁴⁸ Friedman Decl. Ex. R., *Thompson*, 149 F. Supp. 2d at 44. The “Special Questions Report” issued by Metropolitan Life Insurance stated:

In connection with the proposal now under consideration for the insuring of colored lives, it was agreed ... (ii) to use special questions designed to bring out poor environmental, moral hazards, or bad habits, either as part of the regular application or perhaps in the form of a special application to be completed in districts where a substantial proportion of the applications are on low grade risks.

Id. The report also included some suggested questions about the applicant’s home and habits:

- (a) Number of rooms in the home?
- (b) Number of persons living in home, including lodgers?
- (c) Does home contain toilet facilities?
- (d) Does home contain running water?
- (e) Is home in good repair?
- (f) Is home clean? ...
- (a) Does applicant or premium-payer associate with criminals or gamblers such as those in the policy number game?
- (b) Does the applicant or the premium-payer get into fights?
- (c) Have the applicant's or the premium-payer's drinking habits been criticized?
- (d) Is there any other criticism of the applicant's or premium-payer's habits or reputation?

answers would be used to determine or justify the underwriting risk of the policyholder.⁴⁹

II. THE PRESENT LITIGATION

The present wave of litigation against industrial life insurers began with a widely publicized settlement. Florida Insurance Commissioner Bill Nelson filed an order stating that American General continued to collect premiums on racially discriminatory industrial life insurance policies sold by insurance companies it had purchased years ago.⁵⁰ Two months after receiving the order, American General settled for \$206 million.⁵¹ A

Id. The report stated that the questions were “too detailed and otherwise unsuitable” for the standard application and only suitable for a “special application” that would give the insurer grounds for refusing the applicant.

A special application which asks a fairly large number of plain spoken definite questions regarding poor home environment and questionable morals or habits is more likely to elicit an answer on the basis of which the case may be declined, than would a few question, necessarily somewhat generalized, on the regular application. Furthermore, the intent of questions of the type suggested for the special application should soon become obvious to the agent.

Id.

⁴⁹ *Id.*

⁵⁰ Mark Hollis, *Company Cited for Overcharging Poor Blacks for Burial, Life Policies*, SUN-SENTINEL, June 22, 2000, at A1. Senator Nelson, at the time running for office, stated that he became interested in burial insurance after he saw a program where a television crew followed an insurance salesman door to door collecting premiums from low-income residencies, “even prying money out of a family piggy bank with a coat hanger.” *Id.* It is likely that the program dealt with ordinary home life insurance, a different product that also involves door-to-door collection of premiums. Ordinary home life insurance is a topic beyond the scope of this paper.

⁵¹ *Id.* For a detailed description of the negotiations between the Florida Commissioner and American General see American General Life & Accident Insurance Company, Nationwide Settlement, Florida Department of Insurance – Primary Negotiator (unpublished manuscript, on file with Florida State

number of suits and settlements followed in order to correct the racially discriminatory premiums throughout the insurance industry.⁵²

1. Guidry v. Pellerin Life Insurance Company

*Guidry v. Pellerin Life Insurance Co.*⁵³ was a minor suit compared to *In re Monumental*⁵⁴ or *Thorn v. Jefferson-Pilot Life*⁵⁵ (both of which were class-actions), but it was the only industrial life insurance case to offer a holding in regard to the use of race in industrial life insurance.⁵⁶ After a brief preamble about his awareness and the continued presence of discrimination the judge acknowledges that, like many of the other industrial life insurance cases, the defendant “did charge African-Americans as a class, higher premiums than it did Caucasians as a class, for the same life insurance coverage.”⁵⁷ This is followed by the conclusion, and admittedly counterintuitive notion that:

[D]efendant’s differential in the pricing of premiums for life insurance between African-American and Caucasians was based on risk, not race. In that regard, the known risk assumed by defendant for a sum

University), available at http://consensus.fsu.edu/academic_directory/casestudies/2001/Crowell_AmGenIns.pdf.

⁵² See text accompanying note 3.

⁵³ 364 F. Supp. 2d 592. (W.D. La. 2005).

⁵⁴ 365 F.3d 408 (5th Cir. 2004).

⁵⁵ 445 F.3d 311 (4th Cir. 2006).

⁵⁶ The *Corpus Juris Secundum* cites to *Monumental* and *Williams* as cases holding that insurers cannot discriminate based on race; however, both cases were settled without reaching the issue of race. 44 C.J.S. INSURANCE § 43 (2007). See *In re Monumental*, 365 F.3d 408; *Williams*, 237 F.R.D. 685. *Monumental* was settled after the 5th circuit addressed issues of class and statute of limitations. 365 F.3d at 413, 420. *Williams* was a certification of a settlement and only stated that after five years, taking the case to trial would cost a small fortune and possibly bankrupt the National Security Insurance Company before a judgment was reached. 237 F.R.D. at 695.

⁵⁷ *Guidry*, 364 F. Supp. 2d at 593.

certain as it related to insuring the lives of African-Americans and Caucasians was akin to an insurer charging a lower premium to a female than to a male and a higher premium to a smoker than a non-smoker.⁵⁸

The facts of *Guidry* are almost the same as all of the major industrial life insurance cases; the plaintiffs represented a class of African-American and minority policyholders who purchased policies from Pellerin Life Insurance Company.⁵⁹ Pellerin used dual-rate tables until they switched to a dual-plan practice, pushing African-Americans into “higher-priced, inferior policies.”⁶⁰ Pellerin continued to charge their policyholders at the same discriminatory rates.⁶¹ The plaintiffs addressed this problem by bringing suit under 42 U.S.C. §§ 1981, 1982.⁶²

In applying the facts to the framework of §§ 1981, 1982⁶³ the court found that actuarial tables to determine risk were a legitimate, non-

⁵⁸ *Id.* at 594.

⁵⁹ *Id.* at 594-95.

⁶⁰ *Id.* at 594.

⁶¹ *Id.*

⁶² *Id.* at 597.

⁶³ *Guidry*, 364 F. Supp. 2d at 596-97.

To establish an inference of discrimination under §1981, consistent with *McDonnell Douglas*, plaintiffs must allege facts in support of the following elements: (1) the plaintiffs are members of a racial minority; (2) an intent to discriminate *on the basis of race* by the defendant; and (3) the discrimination concerns one or more of the activities enumerated in the statute.

Id. at 596 (citing *Green v. State Bar of Tex.*, 27 F.3d 1083, 1086 (5th Cir. 1994)).

In order to bring an action under § 1982, a plaintiff must allege with specificity facts sufficient to show or raise a plausible inference of the following: (1) the defendant’s racial animus; (2) *intentional discrimination*; and (3) that the defendant deprived plaintiff of his rights because of race.

discriminatory reason for Pellerin's use of dual-plans, and rates.⁶⁴ The plaintiffs attempt to use a decision by the Louisiana insurance commissioner that states that race is considered "unfair discrimination" and violated La. Rev. Stat. 22:1214(7).⁶⁵

La. Rev. Stat. 22:1214(7) was based on the NAIC's Model Unfair Trade Practices Act.⁶⁶ This act was not meant as a form of protection against any vulnerable class, rather it owes its origin to a practice among insurance agents where they would offer a rebate in certain customers to encourage business.⁶⁷ Other applicants would not know if they were paying the same price as the other individuals who contributed to the same pool, so the NAIC offered this model statute to prevent "unfair" discrimination.⁶⁸ It was quickly adopted, in some form, by all 50 states.⁶⁹

Id. at 597 (citing *Shaare Tefila Congregation v. Cobb*, 481 U.S. 615, 616-17 (1987)).

⁶⁴ *Id.* at 597.

⁶⁵ *Id.* at 597-98 (citing LA. REV. STAT. ANN. § 22:1214(7)(a) (2007)):

(7) Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract, *provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor...*

⁶⁶ UNFAIR TRADE PRACTICES MODEL ACT § 4(G) (NAIC 2007) (defining unfair discrimination as an unfair trade practice "[m]aking or permitting any unfair discrimination between individuals of the same class" and similarly situated for rates charged in life insurance policies).

⁶⁷ Jill Gaulding, *Race, Sex, and Genetic Discrimination in Insurance: What's Fair?*, 80 CORNELL L. REV. 1646, 1656-57 (1995).

⁶⁸ *Id.*

⁶⁹ Herman T. Bailey et al., *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779, 782 n.17 (1976).

However, the judge held that Pellerin did not discriminate “between individuals of the same class and equal expectation of life.”⁷⁰ The Louisiana Code § 652⁷¹ specifically states that “fair” was not meant to be interpreted in the usual social context, but in an “efficient” view of fairness, barring practices where the classification of an individual had no relation to their risk, like the rebates La. R.S. 22:1214(7)(a) was supposed to remedy.⁷²

The second challenge the plaintiffs offered was a comparison to a similar favorable case that passed summary judgment, *Brown v. American Capital Insurance Company*.⁷³ *Brown* shared the fact pattern of *Guidry*,⁷⁴ but in *Brown* there was a question of whether the mortality tables were out

⁷⁰ *Guidry*, 364 F. Supp. 2d at 597-98. In a later affidavit the insurance commissioner stated that there was no evidence that Pellerin priced its policies on anything other than life expectancy, and that “after the passage of [LA. REV. STAT. §] 22:652 an insurer charging ‘different groups of people different premium amounts because of differing risk determined by life expectancy, would not violate rule and/or regulations of the Louisiana Department of Insurance or Louisiana statutory law.’” *Id.* at 599.

⁷¹ LA. REV. STAT. ANN. § 22:54 (2008):

No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance *having substantially like insuring risk, and exposure factors, or expense elements*, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. *This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal life expectancies.* (italics in *Guidry*, 364 F. Supp. 2d at 599 n.1).

⁷² *Guidry*, 364 F. Supp. 2d at 599.

⁷³ *Brown v. Amer. Corp. Ins. Co.*, No. Civ. A. 01-2079, 2004 WL 2375796 (E.D. La. 2004).

⁷⁴ *Id.* at *1-2. *See also Guidry*, 364 F. Supp. 2d at 597 (“...as the facts and the expert testimony in the instant action are almost identical to the facts and expert testimony in *Brown*.”).

of proportion to the actual mortality risk of African-American policyholders and to the amount of reserves kept by the insurance company.⁷⁵ The possibility that the rate tables themselves were discriminatory and did not correlate to the risk of the policyholders created a matter of evidence that was not present in *Guidry*.⁷⁶ Brown was fought over the issue of whether those tables were “fair” discrimination, rather than *Guidry*, where there was no evidence of insufficient reserves, biased tables, or anything that would show that the higher premiums were based on racial animus rather than realistic approximations of risk.⁷⁷ So despite the explicit use of race, Pellerin did not actually use race to price the policies, they only used race to gauge the life expectancy of the policyholders which was used to price the premiums.⁷⁸

⁷⁵ *Brown*, 2004 WL 2375796 at *2. “[A] pivotal dispute in this case is whether historically the 41 SSI table reflected underwriting practices, supported by objective factors, which placed the mortality rate for African Americans significantly higher than whites; or whether these socioeconomic underwriting factors were deployed as a ‘mask’ for racial discrimination.” *Id.* The issue was complicated by the fact that the New York Insurance Commissioner actually made the tables, and set the necessary reserves. *Id.*

⁷⁶ *Guidry*, 364 F. Supp. 2d at 598 (“While the expert testimony related to the evidence adduced in *Brown* created a genuine issue of material fact, plaintiffs in this case have failed to introduce any evidence that suggests that the basis of dual-pricing (dual-rate and dual plan practice) was based on *anything other than life expectancy*.”) (italics in original). The defendant’s expert, which the court agreed with, showed the correlation of race and mortality by presenting Society of Actuaries papers from 1952, and 1965 as well as 1961-98 U.S. census data. *Id.*

⁷⁷ *Id.* at 599 (“[P]laintiffs’ opposition to summary judgment is devoid of even a supeon of evidence that the subject insurance policies Pellerin issued were priced in a racially discriminatory manner or that any of Pellerin’s actions were racially motivated.”) (italics in original).

⁷⁸ *Id.* at 598.

Frank Pellerin testified that race was not used in setting an insured’s premium, but rather was used only to determine risk. Because that risk was reflected in the premium paid under some Pellerin policies, African Americans paid a higher premium than Caucasians for the same coverage under those policies. *Id.* (internal citation omitted).

II. WHAT KILLED BURIAL INSURANCE?

Industrial life insurance, and the racial discrimination that accompanied it, died out during the 1960s and 1970s,⁷⁹ but the exact reason why they died is not clear.⁸⁰ Several possible theories are that legislation either stopped racial discrimination in underwriting, or affected industrial life insurance directly. Another theory is that the social climate changed and social pressure pushed the insurance industry to abandon the use of racial discrimination in underwriting and the sale of industrial life insurance. A third theory is that market forces and changes in population demographics drove industrial life insurance from the open market. In this section I will examine each of these theories and see if there is any evidence of their validity. None of these three theories are mutually exclusive, but there is an assumption that needs to be clarified. Industrial life insurance is directly linked to, and relied on racial discrimination.

Industrial life's inefficiency and reliance on racial discrimination is shown in three different ways. First, it was an expensive product, which makes it very vulnerable to any competition that could fill its niche market.

⁷⁹ See e.g., *Moore v. Liberty Nat'l Life*, 108 F. Supp. 2d 1266, 1274 n.5 (11th Cir. 2001) (Liberty National's counsel admitted in the June 20th 2000 hearing that the debit route collection system was dismantled in 1995-96); *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 315 (4th Cir. 2006) (Jefferson stopped issuing policies in 1973, but continued to collect dual rate policies. In 1988 they adjusted the dual rate policies to merging the tables but they still left a difference between the merged tables and the white tables. In 2000 at the time of filing Jefferson declared all dual-rate policies "paid up".) *In re Monumental Life Ins. Co.*, 365 F.3d 408, 412 (5th Cir. 2004) (Monumental and the companies it acquired had not sold dual-rate policies since the 1970's. As early as 1988 some insurers voluntarily adjusted premiums and/or death benefits to equalize coverage.); *Williams v. Nat'l Sec. Ins. Co.*, 237 F.R.D. 685, 687 (M.D. Ala. Aug. 30, 2006) (National Security stopped using dual rates on December 1st, 1980); *Carnegie v. Mut. Life Ins. Co.*, No. CV-99S3292NE, 2004 WL 3715446 at *3 n.18 (N.D. Ala. Nov. 23, 2004) (While Mutual stopped calling the bad policies "colored" in the 1960s the tables were not changed, with the same S for standard policies, and R for substandard policies, except they used occupational proxies for race); see also LIFE INSURANCE FACT BOOK, *supra* note 5, (eds. 1953-97).

⁸⁰ Robert Randall, *Risk Classification and Actuarial Tables as They Affect Insurance Pricing for Women and Minorities*, in DISCRIMINATION AGAINST MINORITIES, *supra* note 16, at 590-91.

Desegregation allowed greater competition which industrial life insurance was not able to handle.

Second, it relied on crude underwriting, particularly assumptions about the mortality of African-Americans. If it was forced to use characteristics that were more costly than an agent's personal assessment it would become too costly, even by its own standards.

Finally, and most compelling, there is the evidence of the timing. There is plenty of evidence of dual rate and dual plan practices and their close connection to the sale of industrial life insurance. The times that insurance companies gave for their discontinuing their discriminatory practices coincide with their abandonment of industrial life insurance as a whole. It looks like if they gave up one, they gave up both. The remaining question is why did industrial life insurance or race based underwriting die at all.

A. THE LEGISLATIVE THEORY

Surprisingly, while a number of states enacted laws that dealt with the use of race in insurance,⁸¹ very few of them prohibited the use of race in underwriting,⁸² and none of them could stop the use of dual-plan discrimination. *Guidry* is interesting because it is evidence that in at least one state there was a surprising lack of legislative action.⁸³ *Guidry* is not proof of this, but it does open up the possibility that race based

⁸¹ See *supra*, p.17 and note 71. See also DISCRIMINATION AGAINST MINORITIES, *supra* note 13, at 195-209. In interviews with various state insurance commissioners, they were not able to tell congress about any negative rights against discrimination in life insurance, and they commented on the difficulty of passing informational laws to prevent abusive practices in the sale of industrial life insurance. *Id.*

⁸² Randall, *supra* note 16, at 195-209. Various insurance commissioners testified to their efforts to reduce discrimination, but the only laws concerning industrial life insurance dealt with disclosure, and that law exempted industrial life insurance. *Id.* at 199.

⁸³ See *Guidry v. Pellerin Life Ins. Co.*, 364 F. Supp. 2d 592, 599 (W.D. La. 2005).

underwriting is more legal than we assume. Under our present laws, *Guidry's* holding could apply to roughly 34 states.⁸⁴

As far as state adoption of legislation that bars the use of race in underwriting life insurance premiums, only thirteen states have adopted statutes specifically prohibiting racial discrimination in life insurance premiums.⁸⁵ Three of those states, Texas, Maryland, and New York, only passed their laws after industrial life insurance was on its last legs in 2009, 1998, and 1984 respectively.⁸⁶ Three other states bar insurers from using race, but only in conjunction with credit scores, and have only done so recently.⁸⁷ Five more states bar the use of race in relation to purchasing, canceling, or limiting the amount of life insurance an applicant can purchase, but do not prohibit racially discriminatory premiums or

⁸⁴ See *infra* note 85 and accompanying text.

⁸⁵ California (CAL. INS. CODE §§ 679.71, 679.72, 10141, 10140 (West 2008)); Connecticut (Conn. Gen. Stat. Ann. § 38a-447 (West 2008)); Delaware (DEL. CODE ANN. tit. 18, § 2304 (West 2008)); Georgia (GA. CODE ANN. § 33-6-4 (West 2008)); Kentucky (KY. REV. STAT. ANN. § 304.12-085 (West 2008)); Maryland (MD CODE ANN., INS., § 27-501 (West 2008) (prohibits discriminatory cancellations, or refusing to offer insurance, and prohibits inquiring about race on applications)); Massachusetts (MASS. GEN. LAWS ANN. 151B § 4(3A) (West 2008) (prohibiting insurers and bondsmen from inquiring about the race of the applicant)); Minnesota (MINN. STAT. ANN. § 72A.12 (West)); New York (N.Y. INS. LAW § 2606 (McKinney 2008)); North Carolina (N.C. GEN. STAT. ANN. § 58-3-25 (West 2008)); Ohio (OHIO REV. CODE ANN. § 3911.16 (West 2008)); Texas (TEX. INS. CODE ANN. § 560.002 (Vernon 2008)); Wisconsin (WIS. STAT. § 625.12 (2008)). New Jersey's statute (N.J. STAT. ANN. §§ 17:29B-4(7)(c), 17B:30-12(a) (West 2008)) was repealed insofar as it applies to life insurers. N.J. STAT. ANN. § 17:36B-3.

⁸⁶ MD CODE, INS., § 27-501 (West 2008) (prohibits discriminatory cancellations, or refusing to offer insurance, and prohibits inquiring about race on applications); N.Y. INS. LAW § 2606 (McKinney 2008); TEX. INS. CODE ANN. § 560.002 (Vernon 2008).

⁸⁷ Iowa (IOWA CODE ANN. § 515.103 (West 2008) (insurers cannot use credit scores that are based on race)); Kansas (KAN. STAT. ANN. § 40-5104 (2008) (insurers cannot use credit scores that are based on race)); New Mexico (N.M. STAT. ANN. § 59A-17A-4(A) (West 2008) (insurer can't use credit scores based on race)). None of these statutes was enacted prior to 2003.

underwriting.⁸⁸ So only 10 states have statutory prohibitions against race based underwriting that could have had an impact on the sale of industrial life insurance.⁸⁹ In the 1950s, when industrial life insurance sales began their long decline, only three states, Connecticut, Massachusetts, and Ohio had enacted laws barring race based underwriting.⁹⁰

On the whole, states that passed laws barring race based underwriting saw a decline in the sale of industrial life insurance in proportion to the national market, with the only exception being Wisconsin.⁹¹ When the sale of industrial life insurance in states barring racial discrimination is compared to states that passed no laws, it is not clear whether the laws were the only factor.⁹² Almost all states saw a drop in the late 1970s, even if they did not pass a law.⁹³ Seven states lost more than one percent of their share of the national industrial life insurance market between 1954 and 1984, but only four of those states passed laws

⁸⁸ Michigan (MICH. COMP. LAWS. ANN. § 500.2027 (West 2008) (cannot refuse to insure, cancel insurance or limit the insurance because of race)); Missouri (MO. ANN. STAT. § 375.007 (West 2008) (cannot refuse to insure, cancel insurance or limit the insurance because of race)); New Hampshire (N.H. REV. STAT. ANN. § 417:4 (2008) (cannot refuse to insure or cancel insurance because of race)); Virginia (VA. CODE ANN. § 38.2-508.2 (2008) (prohibits cancellation based on race)); Washington (WASH. REV. CODE § 49.60.178 (2008) (cannot refuse to insure or cancel insurance because of race)).

⁸⁹ See discussion *supra* note 88 and accompanying text.

⁹⁰ CONN. GEN. STAT. ANN. § 38a-447 (West 2008); MASS. GEN. LAWS ANN. 151B § 4(3A) (West 2008); OHIO REV. CODE ANN. § 3911.16 (West 2008).

⁹¹ Wisconsin dropped 0.12% after passing its anti-discrimination law in 1969, but by 1984 its market share grew 0.13%. See *generally* LIFE INSURANCE FACT BOOK, *supra* note 5 (showing life insurance market share changes over time); see also author charts on file with the Connecticut Insurance Law Journal. To make Chart VI, in the appendix, I found the yearly change in the face value of insurance for each year. The chart shows the average change in face value for all states with laws affecting the underwriting of minorities purchasing industrial life insurance and for states without these laws.

⁹² See *generally* LIFE INSURANCE FACT BOOK, *supra* note 5.

⁹³ See chart 5, *infra* app. 5.

during that time that might have influenced the sale of industrial life insurance.⁹⁴

However, the theory that legislation destroyed the industrial life insurance market is not quite compelling because as some states passed laws barring discrimination, the laws were either ineffective, or the industry shifted to the many other states where it was still legal. Of the ten states that sold the most industrial life insurance in 1954,⁹⁵ four passed laws.⁹⁶ Thirty years later, three out of those four states, as well as New York and Michigan, fell from the top ten.⁹⁷ However, of the twenty-one states that had more than two percent of the national market at any point between 1954 and 1984, seven passed laws.⁹⁸ However, passing laws never led to a state dropping below two percent of the national market.⁹⁹

On the whole, laws barring racial discrimination had an impact on the sale of industrial life insurance in those states, however the impact does not seem to be significant, and the laws only seem to have impacted a small section of the market. What is interesting is the sudden drop-off in the late 1970s. Four states passed laws in the 1970s, and some of those states had a

⁹⁴ Illinois fell 1.06%, Massachusetts 2.92%, New Jersey 1.47%, New York 5.57%, Ohio 1.59%, Pennsylvania 2.24%, Connecticut 1.19%. New Jersey repealed their law for the benefit of life insurers in 1974. Massachusetts, Ohio, and Connecticut also passed laws. Ohio was still one of the top ten states in terms of market share in 1984 despite passing a law barring discriminatory premiums roughly thirty years before. *See generally* LIFE INSURANCE FACT BOOK, *supra* note 5 (showing life insurance market share); *see also* author charts on file with the Connecticut Insurance Law Journal. *See also* Chart VI in the appendix and note 91, *supra*.

⁹⁵ Pennsylvania, 10.2%; New York, 9.3%; Ohio, 6.8%; Illinois, 6.3%; New Jersey 4.8%; California, 4.4%; Texas, 4.3%; Massachusetts 4.2%; Michigan 3.8%; Florida, 3.0%. *Id.*

⁹⁶ Massachusetts, New Jersey, California, and Ohio. *See* discussion *supra* note 85 and accompanying text.

⁹⁷ *See* discussion *infra* Section IV, Part 3.

⁹⁸ *See* author charts on file with the Connecticut Insurance Law Journal.

⁹⁹ *See generally* LIFE INSURANCE FACT BOOK, *supra* note 5, in eds. 1954-1994.

significant share of the national market.¹⁰⁰ Still, the theory that legislation kills industrial life single-handedly has the critical flaw that at the end of its impact on the market, only 10 states passed laws barring the sale of industrial life insurance.¹⁰¹

Another factor that might hurt the legislative theory is the absence of legislation that regulates the industrial life insurance market in particular. All of the statutes mentioned above concerned racially discriminatory premiums. It is not clear whether these statutes were effective in stopping dual-plan practices, and there were no cases litigated during the decline of industrial life insurance to show what impact the few statutes that were passed would have had.

Federal laws, specifically §§ 1981-83¹⁰² may have applied to race based underwriting, but, again, without any litigation or other evidence, nothing supports the theory that the possible application of these federal laws deterred the sale of industrial life insurance to the point where it was driven from the market.

B. THE THEORY OF "SOCIAL REPUGNANCE"

In academic articles, "repugnance" is given as the reason that the industry abandoned racial discrimination.¹⁰³ The insurance industry claims it abandoned dual-rates and dual-plan practices because the differences in

¹⁰⁰ California, Georgia, North Carolina, and Kentucky. All of these states had a significant, greater than 2%, share of the market at the time they passed their laws. *See generally id.*

¹⁰¹ *See discussion supra*, note 95 and accompanying text.

¹⁰² *Guidry*, 364 F. Supp. 2d at 594-97.

¹⁰³ Robert Jerry, II, *Justifying Unisex Insurance: Another Perspective*, 34 AM. U.L. REV. 329, 348 (1985). What is curious about this article is that while it uses society's rejection of race as a factor in insurance to argue for unisex insurance, it cannot point to any law, case, or event that pushed the life insurance industry to reject racial underwriting. Jerry presumes that the change occurred "when insurers realized that the torrent of federal legislation prohibiting racial discrimination in various aspects of society could reach insurance practices if the industry did not take steps to eliminate such discrimination. *Id.* at 367 n.139.

mortality, “were felt to be socioeconomic and hence reflecting them was felt to not be socially acceptable.”¹⁰⁴

There was some public outcry in the late 1970s and early 1980s that add some credibility to this theory. However, some of the recent industrial life class action suits actually turn on the public knowledge of industrial life insurance’s discriminatory dealings.¹⁰⁵ The defendants in those cases referred to negative publicity that industrial life insurance received at the time and argued that the plaintiffs should have been aware of the racially discriminatory practices of industrial life insurers.¹⁰⁶ Among some of the minor news articles were some rather well circulated reports such as an interview on *60 Minutes*,¹⁰⁷ and the hearing before the United

¹⁰⁴ RANDALL, *supra* note 80 at 527. *See also* DOUGLAS CADDY, LEGISLATIVE TRENDS IN INSURANCE REGULATION, 105 (1986) (the insurance industry bases the high mortality of African-Americans on poverty rather than race itself).

¹⁰⁵ *See, e.g.*, *Carnegie v. Mutual Savings Life Ins. Co.*, 99-S-3292-NE, 2002 WL 32989594, *6 (Nov. 1, 2002, N.D. Ala. 2002); *Thompson v. Metro, Life Ins. Co.*, 149 F. Supp. 2d 38, 51 (S.D.N.Y. 2001); *Norflet v. John Hancock Fin. Servs., Inc.*, 422 F. Supp. 2d 346 (D. Conn. 2006). The issue was relevant because various state and federal statute of limitations toll when the plaintiff, using ordinary care, should have discovered the fraudulent concealment. *Carnegie*, 2002 WL 3715446 at *6 (citing *Moore v. Liberty Nat’l Ins. Co.*, 108 F. Supp. 2d 1266, 1273 (N.D. Ala. 2000)).

¹⁰⁶ *Thompson*, 149 F. Supp. 2d at 51 (citing Derek T. Dingle, *Insurance Schemes Still Plague Poor*, NORFOLK J. & GUIDE, June 18, 1980, at A1; Albert Edward Wiggam, *Let’s Explore Your Mind*, THE DETROIT NEWS, September 26, 1936 at 10 (“It is arithmetic not race prejudice that makes life insurance higher for Negroes.”)); Winfred Bryson, *Insurance Companies: An Overview*, BLACK ENTERPRISE, June 1977, at 121-122; Paul M. Barrett, *Delaware Settles Insurance Complaints on Blacks’ Policies With Five Firms*, WALL STREET JOURNAL, August 26, 1988. In total, the defendants in *Thompson* submitted 24 articles over a 60-year span. *Id.*; *See also Carnegie*, 2002 WL at *6 (the defendants submitted 50 articles).

¹⁰⁷ *60 Minutes: Soak the Poor* (CBS television broadcast Jan. 28, 1979). Mike Wallace only briefly mentioned the racially discriminatory aspect of industrial life insurance; much of the program primarily focused on the impact of industrial life insurance on poor Americans in general.

States Commission on Civil Rights.¹⁰⁸ While this shows there was at least some media attention, there was not enough attention to convince the court that the public knew about the issue.¹⁰⁹

There was some official criticism of industrial life insurance during this period as well. The Federal Trade Commission issued a report on industrial life insurance, but it focused on the fact that industrial life insurance was overpriced and inefficient.¹¹⁰ This report led to a widely circulated *Consumer Reports* article,¹¹¹ which in turn led to an investigation by the NAIC.¹¹² Their conclusion was that despite its faults, it served a useful social function.¹¹³

The trouble with the evidence supporting the theory of social repugnance is that industrial life insurance has always had extremely vocal critics.¹¹⁴ These critics provoked inquiries and the inquiries lead to the same conclusions, that industrial life insurance is inefficient but it fills a niche.¹¹⁵ Few of the major criticisms focused on the racial aspect of

¹⁰⁸ *Supra* note 16. However, like the Sixty Minutes piece, the commission touched on industrial life insurance briefly, most of its focus was on gender and it was assured that the use of race based underwriting had already been abandoned. *Id.*; RANDALL, *supra* note 80.

¹⁰⁹ The court in *Thompson* only found that there was a material issue of fact as to whether the plaintiffs were even aware of the issue. *Thompson*, 149 F. Supp. 2d at 52. In *Carnegie*, the court was unconvinced that there was enough media attention to the issue of racial discrimination to alert industrial life insurance policyholders. *Carnegie*, 2002 WL 3715446 at *6.

¹¹⁰ Joan Koonce Lewis, *Home Service Distribution System: A Method of Marketing Life Insurance to the Poor*, 9(1); FINANCIAL COUNSELING & PLANNING 35, 36 (1998).

¹¹¹ *Insurance that Preys on the Poor*, 43 CONSUMER REPORTS 658, 661, Nov. 1978.

¹¹² National Association of Insurance Commissioners, *Home Service Life Insurance: A Commentary* 93, Dec. 1982.

¹¹³ *Id.*

¹¹⁴ *See supra*, pp. 5-6 notes 16-18.

¹¹⁵ *Id.*

industrial life insurance, rather they focused on the way it preys on the poor.¹¹⁶ None of these other past attacks succeeded, so while the presence of criticism certainly contributed to industrial life insurance's decline, it does not explain it.

It would be wonderful to believe that social acceptability guides the insurance industry. However, other practices with a disparate impact on race, such as redlining¹¹⁷ and the use of credit scores,¹¹⁸ as well as the differing treatment of men and women, show that the insurance industry can be strongly attached to unethical practices as long as they are efficient and actuarially sound.

This is not to say that the insurance industry and the people in it are unethical, but that ethical changes may only be possible if the social pressure is stronger than they countervailing economic incentive.¹¹⁹ In this case some of the economic incentives for using race as a tool in underwriting disappeared over time while other insurance products, particularly group life insurance, took away industrial life insurance's comfortable monopoly on the working poor.

¹¹⁶ See e.g., *Thompson*, 149 F. Supp. 2d at 52. Quoting the interview with Mike Wallace, the court calls attention to the fact that the only mention of discrimination was the fact that the majority of consumers of industrial life insurance are African-American. *Id.*

¹¹⁷ See generally GREGORY D. SQUIRES, *INSURANCE REDLINING: DISINVESTMENT, REINVESTMENT, AND THE EVOLVING ROLE OF FINANCIAL INSTITUTIONS* (1997).

¹¹⁸ Credit-scoring is an example of an accurate predictor of risk that had no causal connection to that risk. There were many objections to the use of credit scores and some litigation over them. The social outcry against insurance companies using credit scoring has had more success in the legislator than in the courts. See generally *Safeco Ins. Co. of America v. Burr*, 551 U.S. 47 (2007). After years of protest, forty-eight states passed some kind of law controlling the use of credit scores. See National Association of Mutual Insurance Companies, *State Laws Governing Insurance Scoring Practices*, <http://www.namic.org/reports/credithistory/credithistory.asp> (last visited Feb. 10, 2008) (an index of the state laws and their treatment of credit scoring).

¹¹⁹ See Jerry, *supra* note 93. at 330.

C. OTHER POSSIBLE THEORIES

Two factors that do seem to align with the fall of industrial life insurance are the closing of the racial mortality gap, and the success of group life insurance. The mortality gap between white and African-American policyholders dropped by more than half in the period between the introduction of industrial life insurance in America and its abandonment.¹²⁰ This would have reduced the economic impact of race-blind insurance sales. Group life insurance took off during the same period, offering cost efficient insurance to the same working-class market.

i. *The Mortality Gap*

The difference in the life span and average mortality of African-American policyholders and white policyholders is particularly relevant. It represents an adverse selection risk that the insurance industry would have to accept before they stop using racially discriminatory factors in their underwriting. At the turn of the century there was approximately a 14.6 year difference between the life span of white and non-white Americans.¹²¹ By the 1960s the gap had halved itself and it continued to decline significantly until the 1980s.¹²² In either case, the sale of industrial life insurance leveled off at the same time that the difference between “white”

¹²⁰ See app., p.38.

¹²¹ See app. for comparative charts based on figures from the INSURANCE FACT BOOK.

¹²² LIFE INSURANCE FACT BOOK, *supra* note 5 (ed. 1999) at Table 13.3. In 1900, the difference between the life expectancy from birth of white and “non-white” males was 14.1, between females it was 15.2, and combined it was 14.6. By 1950 it fell to 7.4, 9.3, and 8.3. In 1965 it was 6.5, 7.3, and 6.9. By 1975 it fell to 5.8, 4.9, and 5.4. The mortality continued to drop until the 1980s. The mortality gap has continued to close since that point, but slower, reaching 4.5, 3.2, and 3.5 in 1997. *But see* Robert S. Levine, MD, et al., *Black-White Inequalities in Mortality and Life Expectancy, 1933-1999: Implications for Healthy People 2010*, 116 PUBLIC HEALTH REPORTS 474, 480 (2001) (“We have seen no sustained decrease in black-white disparities in either age-adjusted mortality or overall life expectancy at birth at the national level since the end of World War II...”).

and “non-white” mortality showed its greatest improvements.¹²³ At this point race was not as relevant an underwriting factor as it had been in the past.

The timing of the decline in the mortality gap and the decline in the use of race as a criterion for underwriting is the best evidence that they are related; no publicly available study has mentioned it. It is possible that this is just a coincidence, that the same social and political pressure that improved African-American living conditions and improved mortality rates also provided a social incentive to stop racial underwriting. However, it may be useful to compare the life insurance industry’s quiet abandonment of race based underwriting with its fight to continue sex based underwriting.¹²⁴

The insurance industry has clung to sex based underwriting.¹²⁵ Since the criterion affects all of their policyholders and since the effect is substantial,¹²⁶ the industry claims it would suffer from severe solvency problems if it switched to gender-neutral rate tables.¹²⁷ They believe that men would over-consume life insurance while women abandoned it because their premiums do not correspond to the value of their policies.¹²⁸ The insurance industry has had mixed results in their fight.¹²⁹

¹²³ See app., pp. 37-42.

¹²⁴ See generally United States Commission on Civil Rights, Statement of Richard Minck, Vice President and Actuary, American Council of Life Insurance in *DISCRIMINATION AGAINST MINORITIES*, *supra* note 16, at 224-40.

¹²⁵ See Jill Gaubing, *Race, Sex, and Genetic Discrimination in Insurance: What’s Fair?*, 80 CORNELL L. REV. 1647-49 (1994-1995), for a breakdown of the academic battle over the economic justification of gender discrimination and the arguments against it.

¹²⁶ See app.

¹²⁷ See United States Commission on Civil Rights, Statement of Richard Minck, Vice President and Actuary, American Council of Life Insurance in *DISCRIMINATION AGAINST MINORITIES*, *supra* note 16, at 224-40.

¹²⁸ *Id.*

¹²⁹ See Stephen R. Kaufman, Comment, *Banning “Actuarially Sound” Discrimination: The Proposed Nondiscrimination in Insurance Act*, 20 HARV. J. ON LEGIS. 631, 633 n.22 (1983) for an overview of failed federal legislation

If we compare the industry's differing treatment of sex and race based underwriting from only an economic standpoint the closing racial mortality gap was still rising at the time when it came under fire in the 1970s.¹³⁰

As a result of the closing mortality gap the incentive for any insurance product to use race based underwriting was rapidly dwindling. Combined with the social and legal pressure to stop racial discrimination, various life insurance products began to enter minority markets, competing with industrial life insurance.

ii. *Group Life Insurance*

Group life insurance offered unprecedented competition to industrial life insurance.¹³¹ The decline of industrial life insurance during the 1960 and 1970s corresponds to the point where group life insurance took off.¹³² Both plans appealed to similar demographics, but considering the expense of industrial life insurance, compared to the administrative ease of group life, it is easy to see why group life insurance quickly became one of the strongest life insurance products.¹³³ Contrasting its strengths with

banning the use of gender as a classifier in insurance. Gaulding, *supra* note 63, at 1652-53.

¹³⁰ See app.

¹³¹ See LIFE INSURANCE FACT BOOK, *supra* note 18, at 34 (eds. 1973-77) (stating that industrial life insurance lost 10% of its market share in the decade between the 1960s and 1970s, and that increased availability of group life insurance may have been a factor). Group life insurance, as its name suggests, requires an employer or "central entity" in addition to the insurer and policyholder. RUSS, *supra* note 15, at § 7:1. The central entity acts as the policyholder as they enter into an agreement for the benefit of the employees or group members. *Id.*

¹³² See app.

¹³³ LIFE INSURANCE FACT BOOK, *supra* note 5, at 30 (ed. 1974) (as of 1974, group life was 42% of the insurance market). A reason for the growth of industrial life insurance was that risk aversion, a by-product of the great depression, was a strong factor for many employees and unions. After the war, when employers had to find new employees in a competitive market they found that group insurance was an attractive incentive for hiring as well as retention. HENDERSON, *supra* note 9, at 157-58. By 1954, group insurance was the most popular benefit offered to

the enormous expenses involved in industrial life insurance could explain why industrial life insurance died when it did.¹³⁴

Group plans replace uninformed consumers with a central entity, such as a union, an employer, or an association.¹³⁵ This reduces the informational imbalance between the insurer and the policyholder than leads to dual-plan practices. In addition, group plans have the advantage of skimming a group of the healthiest risks, those who have regular employment, out of the life insurance pool, leaving industrial life insurance the high risk, unemployed, self employed, or irregularly employed individuals.¹³⁶

For minority policyholders, group life insurance offers both statutory and structural protection from discrimination. Structurally, the premiums are fixed to the characteristics of the group rather than the individuals.¹³⁷ This means that while there might be a disparate impact because of racism in hiring, direct discrimination should not be a problem.¹³⁸ Statutorily, discrimination against minorities and women

employees. *Id.* at 157. *See also* app. for charts of the growth of group life insurance.

¹³⁴ One of the advantages of group plans is the low transaction cost, in contrast with industrial life insurance's poor underwriting and premium collection fees. RUSS, *supra* note 18, at § 7:1.

¹³⁵ *Id.* The entity then contracts with the insurer, and acts as the policyholder for the chief contractual relationship. *Id.*

¹³⁶ *Id.* (“[T]hey typical scenario where the insured party is a group of employees, because such group members are by definition healthy enough to be employed at the time they become insured.”).

¹³⁷ MCGILL’S LIFE INSURANCE 817 (Edward E. Graves ed., 3d ed. 2000). The general underwriting considerations are the reason for the group’s existence, its stability, its persistency, the method of determining benefits, the provisions for determining eligibility, the source and method of premium payments, the administrative aspects of the group insurance plan, the prior existence of the plan, the size of the group, the composition of the group (which may include the general age and sex of the group participants), and the industry represented by the group. *Id.* at 817-22.

¹³⁸ *See* DISCRIMINATION AGAINST MINORITIES, *supra* note 16, at 589. While sex and age are used to calculate the group rate, the employee or employer only pays the overall rate rather than their particular portion of it. *Id.* Race is not a

might be allowed at the state level, but additional protection is provided when the group plan is attached to employment and falls under the more expansive laws protecting individuals from discrimination in the workplace.¹³⁹ *Los Angeles Dep't of Water & Power v. Manhart*¹⁴⁰ is an example of how differently the plaintiffs in *Guidry* would have been treated if they were in a group plan covered by federal employment laws. When the Supreme Court in *Manhart* reached the same central issue that was the crux of *Guidry*, whether discrimination based on a protected characteristic is actually “fair” discrimination based on mortality, the court quoted Judge Duniway that “one cannot say that an actuarial distinction based entirely on sex is based on any factor other than sex. Sex is exactly what it is based on.”¹⁴¹

Another more theoretical explanation for group life’s consumption of the industrial life insurance market might involve the reduction of adverse selection risks when the insurance is attached to a more vital attribute of the consumer.¹⁴² Some kinds of insurance pools require a

factor in their underwriting because of “its social unacceptability, but the proportion of our total population that is nonwhite is so small (10 percent) that the impact has been minimal.” *Id.*

¹³⁹ See generally *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702, 708-10 (1978).

¹⁴⁰ *Manhart*, 435 U.S. 702. *Manhart* dealt with an employer who required female employees to contribute 14.84% more to the employee retirement funds than their male coworkers to compensate for the difference in their mortality. *Id.* at 704-05. In *Manhart* the court held that Title VII focused on individuals and precluded their treatment as part of “a racial, religious, sexual, or national class.” *Id.* at 708 (“The statute makes it unlawful ‘to discriminate against any *individual* with respect to his compensation, terms, conditions, or privileges of employment, because of such *individual’s* race, color, religion, sex, or national origin.’”) (quoting 42 U.S.C. § 2000e-2(a)(1) (emphasis in *Manhart*)).

¹⁴¹ *Manhart*, 435 U.S. at 712-13 (quoting *Manhart v. City of Los Angeles, Dep't of Water & Power*, 553 F.2d 581, 588 (9th Cir. 1976) (internal quotation marks omitted)).

¹⁴² The theory behind adverse is that when a high risk section of the market is offered insurance at the same rate as the low risk portion of the market, the high risks may over-consume insurance, forcing up the claims, and driving the price of insurance past the point where it becomes a reasonable investment for lower risk

common attribute from the policyholders, like church attendance,¹⁴³ union membership, or employment.¹⁴⁴ The purchase of insurance may be seen as a socially driven act of collective reasonability. This both keeps low risks in an insurance pool when they may find better offers on the open market, and it stops high risk individuals from over insuring by preventing any individual from buying more than a set amount of insurance under a single policy, or preventing them from purchasing multiple policies. This might explain the survival of mutual benefit societies into the early 20th century, despite their lack of underwriting.¹⁴⁵ It also would explain how the “death spiral” is more apparent when the choice between two competing pools is not dependant on any shared social attribute of the policyholders.¹⁴⁶

Industrial life insurance policyholders are not unified by any social bond or attribute that would prevent high-risk individuals from over-insuring themselves at the expense of low risk applicants. Actually, industrial life insurance’s rudimentary underwriting techniques¹⁴⁷ allow

individuals. When low risk individuals are driven out of the insurance pool, the rate of claims become higher then the value of the pool and forcing the insurance provider into liquidation. See generally Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976).

¹⁴³ See HENDERSON, *supra* note 12, at 12-13.

¹⁴⁴ Group life insurance, as its name suggests, requires an employer or “central entity” in addition to the insurer and policyholder. See Russ, *supra* note 18, at § 7:1. The central entity acts as the policyholder as they enter into an agreement for the benefit of the employees or group members. *Id.*

¹⁴⁵ See Peter Siegelman, *Adverse Selection In Insurance Markets: An exaggerated Threat*, 113 YALE L.J. 1223, 1255 (2003-2004) (“mutual assessment societies” survived in Canada and America into the 1920’s).

¹⁴⁶ See generally David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1 FRONTIERS HEALTH POL’Y RES. 1 (1998). Here, Harvard offered its employees a choice between an expensive PPO and an in expensive HMO. When budget cuts forced the university to adjust the premiums of the plans to their actual cost, the younger, healthier, lower risk individuals switched to the cheaper plan. When the premiums were adjusted the next year the departure of the low risks raised the premiums, driving more low risks out of the PPO until, within two years of the initial premium adjustment, it was disbanded. *Id.* at 13-14.

¹⁴⁷ *Cost and Coverage of Industrial Life Insurance*, *supra* note 9, at 47.

high-risk individuals to hide health problems.¹⁴⁸ It is clear why high mortality helped drive up the price of industrial life insurance so drastically.¹⁴⁹ The only protection against this is the vigilance of the agent, and the low caps on each industrial life insurance policy.¹⁵⁰

On the other extreme, group life insurance policyholders must have a unifying attribute; states will not allow a group to obtain insurance if that is the group's only purpose.¹⁵¹ This attribute may compensate for over-consumption of insurance by high-risk individuals.

Because of the structure of life insurance, its costs, and federal laws that apply to employment, group life offers many more protections against discrimination, while also supplying competition against industrial life insurance. This competitive replacement for insurance was certainly part of the reason why industrial life insurance died without much social pressure and legislative action.

¹⁴⁸ *Id.* at 47. There is usually a clause allowing the insurance company to rescind the policy if the applicant lied about the condition of their health. DAVIS, *supra* note 13, at 34.

¹⁴⁹ *Cost and Coverage of Industrial Life Insurance*, *supra* note 9, at 50 ("The mortality rate of industrial policyholders is indeed 20 per cent higher than that of ordinary life insurance policyholders.").

¹⁵⁰ One argument against the risk of adverse selection is that premiums for life insurance fall as more insurance is purchased. Siegelman, *supra* note 145, at 1280 (citing John Cawley & Thomas Philipson, *An Empirical Examination of Information Barriers to Trade in Insurance*, 89 AM. ECON. REV. 827, 841 (1999)). This is counter intuitive since high-risk individuals should be the ones over-consuming, and reducing their rate of consumption would drive up the cost of insurance. *Id.* However, industrial life insurance does not offer this feature, but demands that applicants purchase multiple policies to reach their desired level of protection. *Willis v. Life Ins. Co. of Georgia*, No. 400CV323PB, 2001 WL 34403088, at *2 (N.D. Miss. May 31, 2001); *Justin v. Metro. Life Ins. Co.*, No. 00-2208, 2000 WL 1741858, at *2 (E.D. La. Nov. 20, 2000). While this does not conform to a prediction that rationing to avoid adverse selection would mean increasing the price of subsequent policies, it shows a trend toward reducing the risk of over consumption by high-risk individuals.

¹⁵¹ RUSS, *supra* note 18, at § 7:7.

CONCLUSION

None of these theories are entirely satisfactory, but taken together they form a rough understanding of what happened; An inefficient product was driven from the market when its costs grew and its advantages were lost.

Social repugnance is certainly a cost, and while most insurance products were able to adapt by ending race based underwriting, industrial life insurance could not. In some instances, such as the use of redlining and credit scores, the insurance industry has been willing to pay the social cost of an unpopular but profitable tool.¹⁵² In those instances the only thing that stopped the industry, was legislation and legal action.¹⁵³ In the case of race based underwriting the industry may have realized that racially discriminatory pricing and practices were becoming less and less useful while their social repugnance rose. There was no reason to wait for the inevitable social backlash. When the majority of the insurance industry abandoned their use of race in both their products and their hiring practices it took away industrial life insurance's monopoly on the African-American market.¹⁵⁴ Industrial life insurance's inefficiency was only tolerated because consumers had few realistic alternatives.¹⁵⁵ Once that reason fell away the product did as well.

One of the lessons that the death of industrial life insurance can teach is the inefficiency of racism. When racist practices disappear we expect that it is the result of a social or political effort to rub out the offensive practice. In this case, whatever economic advantage industrial life insurance had slowly dwindled without much of a concerted effort and died when it was confronted with more efficient products. While there was some social repugnance it was similar to other inquiries and outrages that

¹⁵² See *supra* notes 117-118, at 27 and accompanying text. The perfect example of this is the life insurance industry's discrimination against the elderly. The elderly are certainly a vulnerable minority, but no amount of social repugnance could stop them from using an incredibly accurate underwriting criterion.

¹⁵³ E.g., *supra* note 118, at 27.

¹⁵⁴ The best evidence of this is the collapse of African-American owned life insurance companies, who primarily provided industrial life insurance, after desegregation. See *supra* notes 28, 34, at 8-9 and accompanying text.

¹⁵⁵ See *supra* notes 18-20, at 5-6 and accompanying text.

industrial life insurance had weathered in the past. While there was some legislation, its effect was limited and probably unnecessary. The social changes that closed the mortality gap and increased the number of African-Americans enrolled in group life insurance plans were probably as significant as any concerted effort to end industrial life insurance directly.

Chart I: Mortality Rate from Birth Among Selected Groups

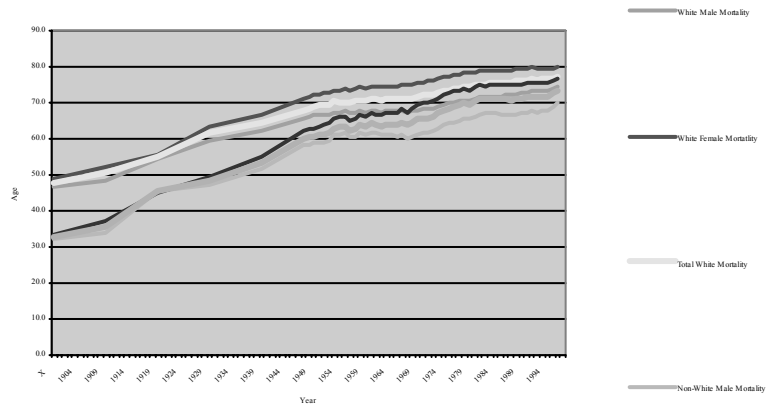


Chart II: Difference in Mortality Between "White" and "Non-White" Americans

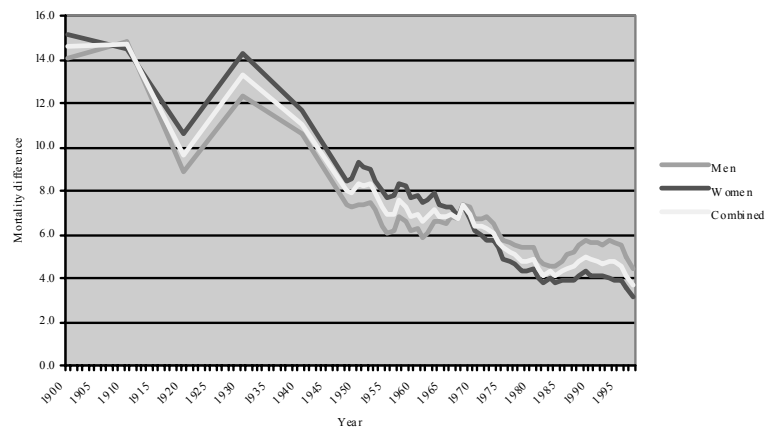


Chart III: The Number of Group and Industrial Life Insurance Policies Outstanding (000,000 Omitted)

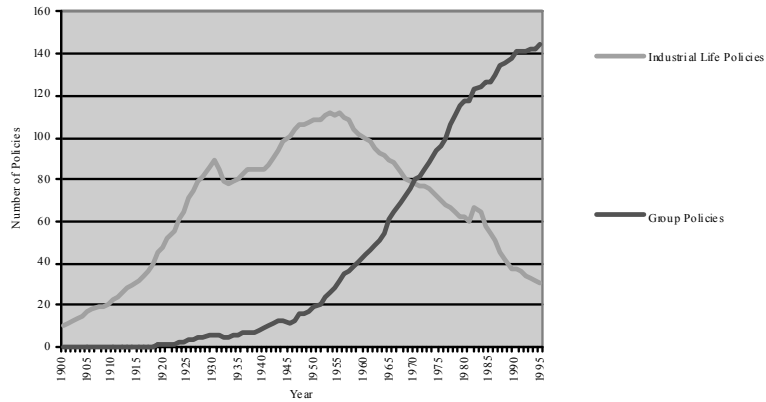


Chart IV: Face Value of the Group and Industrial Life Insurance Policies In Force for the Period of 1940-60 (000,000 on

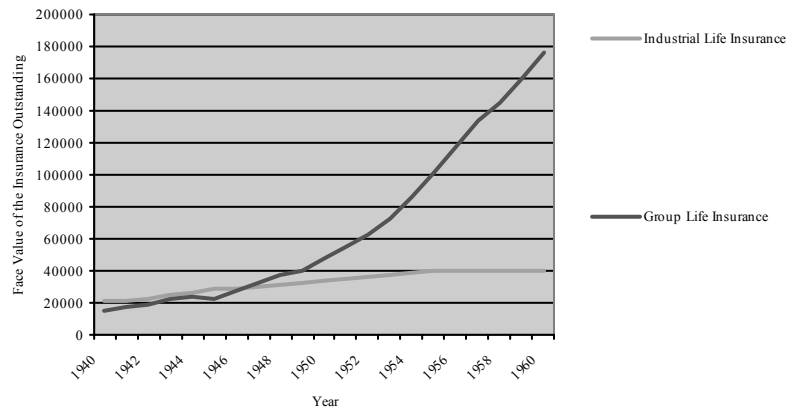
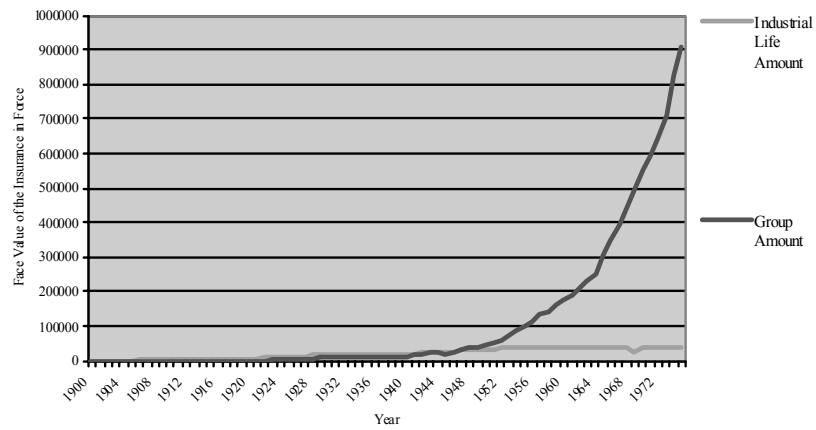
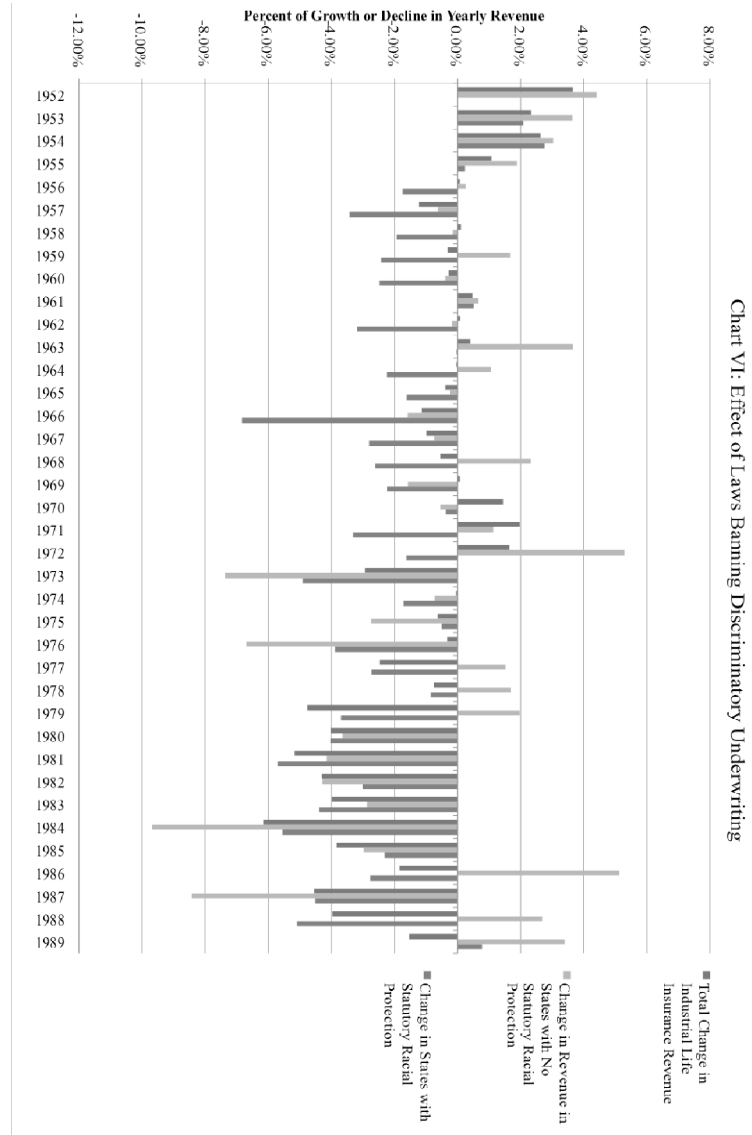


Chart V: Face Value of the Group and Industrial Life Insurance in Force for the Period of 1900-75 (000,000 omitted)





INSURANCE INTERMEDIARIES

Hazel Beh^{*}
Amanda M. Willis^{**}

INTRODUCTION

The Association of American Law Schools Insurance Law Section's 2008 meeting was devoted to an examination of insurance intermediaries. Intermediaries play a critical middleman role in the distribution and operations of insurance. Besides bringing insureds and insurers together, intermediaries also provide advice to insureds, gather underwriting information for insurers, and generally help facilitate the relationship between insured and insurers all the way through the claims process. Despite the critical importance of intermediaries, judicial decisions considering the duties, obligations, and loyalties of intermediaries have left the law muddled and insureds largely unprotected.

In 2004, the New York Attorney General launched an investigation into whether the common compensation schemes offered to insurance intermediaries by insurers had induced intermediaries to improperly steer their clients' insurance business to those insurers paying the most lucrative commissions, without regard to their client's interests. New York's investigation raised the question of whether the longstanding practice of paying brokers contingent commissions undermined broker loyalty and tainted the broker-insured relationship. The investigation and its aftermath revealed the vulnerabilities of insureds to the undisclosed practices of insurers and intermediaries. Impoverished case law on the loyalties and duties owed by intermediaries to insureds, together with ignorance about the conflicts raised by compensation and contingent commissions likely exacerbated the problem. Thus, the time to look more closely at intermediaries was long overdue.

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This article explores the role of the intermediary in the context of insurance in order to introduce reflections on intermediaries presented by Professors Jeffrey Stempel, Daniel Schwarcz, and others at the 2008 AALS program. Daniel Schwarcz considers the problems of compensation schemes in the context of both commercial and personal lines of insurance.¹ Jeffrey Stempel examines the relatively unexamined role of intermediaries employed after the formation of the insurance contract, including so-called independent claims adjusters and managing general agents.²

Part II discusses the various methodologies employed to understand the legal relationship of intermediaries to insurers and insureds. It concludes that principles of agency law do not provide a particularly helpful framework to understand the legal relationships among insured, insurer, and their intermediary because the intermediary's role, even in a single transaction, is inconstant.

Part III discusses judicial treatment of claims against intermediaries. It finds the outcomes are fact-driven and unpredictable; it is often difficult for courts to determine to whom an intermediary owes its duties. It observes that courts frequently impose a relatively low standard of care toward insureds upon intermediaries. The majority of courts apply a low standard of care even to those intermediaries who are deemed brokers working for the insured, and captive and independent agents have even lesser obligations. The judicial treatment of intermediaries is out of step with the pro-insured treatment courts generally adopt in disputes between insurers and insureds.

Part IV then briefly considers whether contingent commissions paid by insurers to intermediaries add further mischief to already confused legal relationships. It introduces two views to be considered.

Professor Daniel Schwarcz contends that dangers indeed exist, particularly the temptations of improper steering, and that disclosure of intermediary compensation schemes to insureds is not sufficiently

¹ Daniel Schwarcz, *Differential Compensation and the "Race to the Bottom" in Consumer Insurance Markets*, 15 CONN. INS. L.J. 878 (forthcoming).

² Jeffrey W. Stempel, *The Other Intermediaries: The Increasingly Anachronistic Immunity of Managing General Agents and Independent Claims Adjusters*, 15 CONN. INS. L.J. 741 (forthcoming).

protective.³ Schwarcz posits that even if “consumers understand their intermediaries face a potential conflict” they cannot on their own “police the quality of the advice they receive from their intermediaries or ... calculate the expected costs of this limitation.”⁴ Schwarcz believes that disclosure is insufficient even in the commercial insurance market with sophisticated insureds, because even equipped with that disclosure, insureds will lack a means to protect themselves.⁵ Schwarcz proposes methods to reduce or eliminate the conflicts raised by compensation, including perhaps by moving away from differential compensation in the consumer insurance markets altogether.⁶

On the other hand, insurance insider Sean Fitzpatrick contends that we should not abandon the contingent commission scheme, rather that adding the safeguards of mandatory disclosure of compensation practices should suffice.⁷ Fitzpatrick argues that the incidents of improper steering and the conflicts raised by contingent commissions are exaggerated.⁸ Moreover, he views contingent commission schemes as beneficial to consumers, because they encourage intermediaries to consider “long-term” performance of insurers.⁹

³ Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL’Y REV. 289, 324 (2007) (concluding that contingent commissions should be banned in the consumer market and possibly banned in the commercial market as well).

⁴ *Id.* at 323.

⁵ *Id.* at 325-26.

⁶ Schwarcz, *Differential Compensation*, *supra* note 1.

⁷ Sean M. Fitzpatrick, *The Small Laws: Eliot Spitzer and the Way to Market Reform*, 74 FORDHAM L. REV. 3041, 3067-71 (2006) (calling for voluntary disclosure of compensation mechanisms). Sean M. Fitzpatrick is employed within the insurance industry. He currently holds a Senior Vice President position with The Chubb Corporation.

⁸ *Id.* at 3061-62.

⁹ *Id.* at 3061.

Part V briefly comments on Jeffrey Stempel's viewpoint on outsourced independent adjusters and managing general agents – those intermediaries employed by insurers to facilitate insurance functions after the policy has been issued. He notes that bottom line interests have made outsourcing these insurance tasks more common. Stempel cautions that although these intermediaries carry out important functions associated with insurance, the lack of regulation and a lack of viable legal theories (particularly bad faith) against downstream intermediaries leaves them largely immunized for their own errors. Stempel argues that expanding tort liability to outsourced adjusters and administrators will improve accountability, advance public policy, and enhance the effective operation of the insurance market.¹⁰

Discussions about the legal status of intermediaries, the conflicts of interest they encounter, and their potential liability to insureds has been little explored or understood. Their role in the marketing, processing, and management of insurance is vital and increasing.

I. CLASSIFICATION OF INTERMEDIARIES

Insurers have access to a wide “variety of marketing channels.”¹¹ These channels include direct marketing to buyers, through means such as soliciting by Internet, mail, and company employees.¹² To a large extent, however, insurers rely on insurance intermediaries of various kinds to sell their products.¹³

In direct writing, the insurer does not utilize an intermediary, but engages in mass merchandising of its own insurance products.¹⁴ Direct

¹⁰ Stempel, *supra* note 2, at 741.

¹¹ See J. David Cummins & Neil A. Doherty, *The Economics of Insurance Intermediaries*, 73 J. Risk & Ins. 359, 360 (2006). See also Background on Insurance Intermediaries, 2004 Ins. Info. Inst. 4, available at http://server.iii.org/yy_obj_data/binary/774206_1_0/InsuranceIntermediaries.doc.

¹² See Cummins & Doherty, *supra* note 11, at 360; Background on Insurance Intermediaries, *supra* note 11, at 4.

¹³ See Cummins & Doherty, *supra* note 11, at 360 (stating “the vast majority of commercial [property and casualty] insurance sales involves an intermediary”).

writers are employees of the insurer, working as the insurer's sales force and representing only the insurance company. With a direct writer, there is often no face-to-face contact with a prospective insured, and no local agent. Instead, communications are through employees, and via phone, mail, fax, and Internet. Direct writers are simply the insurer's own sales force.

Often, however, insurers use intermediaries to sell insurance, and to bring insurers and prospects together. These intermediaries perform an essential service in the insurance market that enables both the insured and the insurer to transact business. Intermediaries may be labeled as "captive agents," agents that principally sell the products of a single company; "independent agents" that typically sell for several insurers;¹⁵ and brokers, that are engaged by insureds to procure insurance on their behalf. Brokers "tend to service larger and more complicated business insurance needs."¹⁶ Large brokers, with a global reach, are "highly concentrated" and "the bulk of commercial [property and casualty] lines for the large and international buyer segment of the market is placed by a small number of brokers for each of whom it is their biggest source of revenue."¹⁷

While there are numerous ways to classify intermediaries, each merely describes aspects of their role. Commentator Sean Fitzpatrick observes, "[i]ndeed, one can hardly locate an in-depth legal analysis of the broker-agent distinction that does not feature words such as 'blurry' or 'cloudy.'"¹⁸ Determining what intermediaries do and for whom they work has not lent itself to easy answers; definitive characterizations have been illusive. The intermediary's relationship with the insurer and the insured must often be determined on a case-by-case basis.

Among the ways to characterize intermediaries are a) by the exclusivity-independence they have established in their contractual relations with insureds and insurers; b) by the extent to which the insurer's mode of market distribution utilizes intermediaries; and c) by principles of

¹⁴ Laureen Regan & Sharon Tennyson, *Agent Discretion and the Choice of Insurance Marketing System*, 39 J. L. & ECON. 637, 638, 640 (1996).

¹⁵ Robert H. Jerry, *Understanding Insurance Law* 64 (3d ed. 2002).

¹⁶ Cummins & Doherty, *supra* note 11, at 361.

¹⁷ *Id.* at 363, 367.

¹⁸ Fitzpatrick, *supra* note 7, at 3054.

agency law, including the nature of the agent's authority vis-à-vis the insured or insurer. However, as described below, while these classification exercises may help us understand the role of the intermediary, each does little to help us understand the legal relationship between the intermediary, the insurer, and the insured.

Characterization of intermediaries by the independence or exclusivity they maintain is often unsatisfactory because the actual relationship an intermediary has with insurers and insureds may be less categorical.¹⁹ Many are neither strictly exclusive agents working for an insurer nor strictly independent agents working for an insured. For example, a "captive" agent is one who purportedly sells for a single insurer and ought to be the most clearly an agent of the insurer. Yet a captive agent may sell insurance products of other companies in some circumstances.²⁰ Moreover, by conduct directed toward the insured, a captive agent may transform from an agent of the insurer to one for the insured in a particular case.²¹

Just as captives may not be strictly captive, "independent" agents are in fact be less independent than that label implies. Although agents are called "independent," implying that they are free from ties to any particular insurance company, independent agents usually sell only for a handful of insurers with whom they have agency appointment contracts.²² Importantly, although they have the independence to place insurance with

¹⁹ See, e.g., *Quirk v. Anthony*, 563 So.2d 710, 712 (Fla. App. 1990) (whether an agent works for insured or insurer presented a triable issue of fact).

²⁰ *Cummins & Doherty*, *supra* note 11, at 361. Captive agents may be employees or independent contractors. *Regan & Tennyson*, *supra* note 14, at 637-38 (1996).

²¹ See *Campbell v. Valley State Agency*, 407 N.W.2d 109, 112 (Minn. App. 1987) ("agent may undertake an affirmative duty by entering into a special relationship with an insured").

²² In 2000, "the average independent insurance agency ... represented 7.3 personal lines insurers, 6.7 commercial lines insurers, and 4.8 life and health carriers." *JERRY*, *supra* note 15, at 64.

multiple insurers, they are not necessarily agents for the insured.²³ Independent agents are vested with authority to perform certain acts for the insurer and are paid commissions by the insurer based upon agreements with particular insurers.²⁴

Brokers, whose name implies that they work for the insured and negotiate contracts on the insured's behalf,²⁵ are also not as independent as their name implies. Brokers who purport to work for the insured also may "place a significant portion of their business" under agency appointment contracts.²⁶ These contracts vest authority in brokers to perform certain services for the insurer. This may be so even where the broker also charges the insured a separate fee for their services.²⁷ Thus, brokers in fact may be working on behalf of both the insured and the insurer in a particular transaction.²⁸

Modes of market distribution may also help to characterize the role of the intermediary. Modes of distribution tend to sort by the nature of the lines sold.²⁹ Personal lines, sold to consumers, are more frequently distributed through direct marketing by insurance employees or through

²³ See *Watkins v. HRRW, LLC*, No. 3:05-00279, 2006 WL 3327659, at *7 (M.D. Tenn. Nov. 14, 2006) (observing that independent agents may be agent of the insured, but also for the insurer for some functions).

²⁴ *Cummins & Doherty*, *supra* note 11, at 374-78.

²⁵ The dictionary defines a broker as "an agent middleman who for a fee or commission negotiates contracts of purchase and sale... between buyers and sellers..." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 281 (3d ed. 1981).

²⁶ *Cummins & Doherty*, *supra* note 11, at 361. See generally *Md. Cas. Co. v. J.M. Foster*, 414 P.2d 672 (N.M. 1966) (agency agreements authorized independent agent to bind and place insurance with four companies).

²⁷ *Cummins & Doherty*, *supra* note 11, at 376-79 (observing that fees charged to insured clients are "offset by commissions").

²⁸ See *Almerico v. RLI Ins. Co.*, 716 So.2d 774, 776-77 (Fla. 1998) ("it is equally well settled that an insurance broker may act in the dual capacity of broker for insured and agent of the insurer").

²⁹ See *JERRY*, *supra* note 15, at 64.

captive and exclusive agencies.³⁰ Commercial lines are more often distributed through so-called independent agents and brokers.³¹ Notably, some insurers now market through several distribution channels, “blurring the boundaries that used to exist among insurers based upon distribution.”³²

Intermediaries may also be characterized by agency principles, particularly by the intermediary’s relationship to its principal, and the level of authority vested in them. The problem here is that insurers vest varying degrees of authority in agents, defying classification by their title. A general agent, enjoying the broadest authority on behalf of an insurer, “is authorized by an insurer to accept risks, to agree upon and settle the terms of insurance policies, to issue and renew policies, and to modify or waive the terms of existing policies.”³³ “The powers of such an agent are coextensive with the business entrusted to his care, authorizing him to act for the principal in all matters coming within the usual and ordinary scope and character of such business.”³⁴

Insurers conduct much of their business through the use of intermediaries with more limited authority. These limited authority agents

³⁰ *Id.* (characterizing captive agents and insurance marketing through insurer employees directly to buyers as examples of direct marketing).

³¹ See Cummins & Doherty, *supra* note 11, at 362 (noting that independent agencies and brokers “control 32 percent of personal lines business” and 68 percent of commercial lines of property and casualty.); Regan & Tennyson, *supra* note 14, at 653 (observing the dominance of exclusive agencies in personal lines and dominance of independent agents in commercial lines). More specifically,

Firms which use tied sales [exclusive agents] agents sell nearly 80 percent of life-health insurance but hold only a 45 percent market share in property-liability insurance; the remainder of each of these markets is sold by firms using independent sales agents. The distribution of market shares by organizational form is also systematic within more narrow classes of insurance: for example, independent agency firms sell only 35 percent of private passenger auto insurance but control 65 percent of the commercial auto insurance market.

Id. at 638.

³² JERRY, *supra* note 15, at 65.

³³ Douglas Richmond, *Insurance Agent and Broker Liability*, 40 TORT TRIAL & INS. PRAC. L.J. 1, 3 (2004).

³⁴ Wash. Nat’l Ins. Co. v. Strickland, 491 So. 2d 872, 874 (Ala. 1985).

are “authorized to act for the principal only in a particular transaction or in a particular way.”³⁵ Agents with limited authority to bind insurers are characterized as “special agents,” and include “soliciting agents,” who are not authorized to bind the insurer, but are authorized only “to solicit insurance, to take applications for insurance and forward them to the company or its general agent, to deliver policies once issued by the insurer, and to collect premiums.”³⁶ Although agents with limited authority cannot bind the principal beyond the scope of that authority, the principal may still be liable for the agent’s conduct, for example, when the agent commits fraud under ‘respondeat superior’ principles.³⁷

Characterizing the loyalties and duties of intermediaries by examining the agent-principal relationship is imperfect at best, because whether the insured or the insurer serves as the principal can depend on the actual tasks performed. Intermediaries, both independent and exclusive, perform valuable services that are desired and beneficial to both prospective insureds and insurers.³⁸ Thus, “[a]lthough an independent agent or broker is normally an agent for the insured, for some purposes he may be an agent for the insurer as well.”³⁹ Determining for whom the

³⁵ *Id.*

³⁶ Richmond, *supra* note 33, at 4.

³⁷ *Washington*, 491 So. 2d at 874-75.

³⁸ Intermediaries can be characterized as “two-sided firms.” Cummins & Doherty, *supra* note 11, at 361 n.3.

Three conditions must be present in a two-sided market: (1) two distinct groups of customers; (2) the value obtained by one group increases with the size of the other; and (3) an intermediary connects the two. Coordination of two-sided markets requires that this intermediary or “middleman” create a platform for the groups to interact. The intermediary must ensure the existence of a critical mass on both sides.

Timothy J. Muris, *Payment Card Regulation and the (Mis)application of the Economics of Two-sided Markets*, 2005 COLUM. BUS. L. REV. 515, at 517. As a result, each side of the market intermediaries bring together may to some extent subsidize the other. *Id.*

³⁹ *Washington*, 491 So. 2d at 875. *See also* Young v. Allstate, 812 N.E.2d 741, 752 (Ill. App. 2004) (“An independent broker may act as agent of the insurer and insured in certain circumstances.”).

intermediary works in any given transaction at any point in time involves a complicated factual inquiry.⁴⁰ Determining for whom an intermediary works may also require a factual analysis of how the intermediary was engaged in this particular transaction.⁴¹

Insurers utilize intermediaries not only to sell their products, but also to gather information utilized during the underwriting process, and to provide services on behalf of the insurer to insureds during the coverage period.⁴² As Regan and Tennyson observe, to ensure profitability, “insurer[s] must devise an effective method of classifying applicants.”⁴³ Generally, when underwriting requires gathering more sophisticated or complex risk information, insurers utilize the services of independent agents rather than captive agents.⁴⁴

⁴⁰ See Richmond, *supra* note 33, at 7-9. Richmond comments that brokers “may be an agent of the insured for purposes of obtaining coverage” but an agent of the insurer for purposes such as “issuing policies, issuing certificates of insurance, collecting premiums, and the like.” *Id.* at 7-8.

⁴¹ See Young, 812 N.E.2d at 752 (quoting *Farmers Auto. Ins. Ass’n v. Gitelson*, 801 N.E.2d 1064, 1068 (Ill. App. Ct. 2003) (identifying four factors to determine to whom a broker owes a duty as “1) who first set the agent in motion; 2) who controlled the agent’s action; 3) who paid the agent; and 4) whose interests the agent was protecting”).)

⁴² Regan & Tennyson, *supra* note 14, at 638-39. As Regan & Tennyson explain the agent’s value in underwriting:

Although insurance sales agents do not typically participate in the formal underwriting process, they frequently play an important role in applicant risk assessment. The agent is the first contact the insurer has with a potential policyholder and may be able to obtain information about the consumer which would be difficult or costly for the firm to verify. It is widely acknowledged that agents often employ subjective criteria in evaluating insurance applicants. The agent’s information may then be used by the insurer in the decision regarding whether to insure, or under what conditions to insure, an applicant.

Id. at 639.

⁴³ *Id.* at 638.

Prospective insureds also benefit from the expertise and labors of intermediaries. A buyer, whether sophisticated or not, would be hard pressed to intelligently compare characteristics of insurance products beyond the premium charged without the expertise of an intermediary. For example, nuances in policy language, insurer solvency, claims practices, and reputation of the insurer are matters for which even sophisticated insureds need the counsel of intermediaries. “[T]he buyer of insurance faces the daunting task of first deciding what sort of insurance protection is needed given the risks faced, and then comparing policies offering alternative coverage at different prices from several insurers with different levels of credit risk and reputations for claims settlement and policyholder services.”⁴⁵ Buyers, thus, turn to intermediaries to “match buyers with insurers who have the skill, capacity, risk appetite, and financial strength to underwrite the risk, and then help the client select from competing offers.”⁴⁶

Despite their vital functions in the insurance market, the inconstancy and vagueness of their legally prescribed allegiances is problematic. In any given intermediary relationship, the intermediary, the insured, and the insurer cannot be certain for whom the intermediary is working. Each time, ad hoc, and without definitiveness, courts must ask if the intermediary was working in their own self-interest, the interest of the insured, or the interest of the insurer.

II. TREATMENT OF INSURANCE INTERMEDIARIES IN THE COURTS

A. THE INTERMEDIARY’S STANDARD OF CARE

Although the relationships between insurer, intermediary, and insured are complex and not easily categorized, cases have frequently

⁴⁴ *Id.* at 663. The authors explain that the advantage of utilizing independent agents “arises because the independent agent’s multiple placement opportunities and ownership of policy expirations reinforce his incentives to participate in risk assessment, thereby lowering the insurer’s marginal cost of obtaining agent information.” *Id.*

⁴⁵ Cummins & Doherty, *supra* note 11, at 359-60.

⁴⁶ *Id.* at 360.

adopted a relatively simplistic approach in disputes between insureds and intermediaries. In litigation between intermediaries and their insureds, little judicial attention is paid to the peculiar vulnerabilities of insureds, even though these same courts have developed special protective rules to protect insureds in the context of suits between insureds and insurers.

Professor James Fischer, explaining why insurance contracts traditionally have been judged contractually by special rules, explains that insurers enjoy such a uniquely superior position in the relationship that it is proper to treat the insurer-insured contract differently than any other.⁴⁷ There are a variety of justifications for special rules. To name a few, insurers are repeat players with greater knowledge and sophistication about insurance than consumers. Insurers understand more about risk and about the nuances and complexities of coverage and non-coverage in the context of endless factual uncertainties that may arise. Insurance contracts are super-adhesionary; insurers have unilaterally and carefully drafted the insurance policy, and are unwilling to negotiate the language of the document. Most importantly, Fischer explains, insurers hold substantially more information than insureds about nearly every aspect of insurance, and can use this asymmetric possession of information to their advantage.⁴⁸ Reasonable expectations, contra proferentum, estoppel, and most notably the tort of bad faith are all judicial inventions aimed at leveling the playing field for insureds.⁴⁹ Likewise, for the other important intermediary in the third-party insurance context, the defense attorney, courts have created extraordinary safeguards to protect insureds.⁵⁰

⁴⁷ See James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995, 1049-50 (1992).

⁴⁸ *Id.* at 1050-51.

⁴⁹ See Hazel Glenn Beh, *Reassessing the Sophisticated Insured Exception*, 39 TORT TRIAL & INS. PRACT. L.J. 85, 85-86 (2004) (discussing justifications for pro-insured canons of contract interpretation, “including the adhesive quality of the insurance product, the parties’ relative bargaining power, the relation of trust, the parties’ asymmetric access to information, the unique nature of insurance, and the quasi-public nature of the insurance industry”).

⁵⁰ See, e.g., *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc’y, Inc.*, 208 Cal. Rptr. 494, 496 (Cal. Ct. App. 1984) (allowing insured separate and

The imbalance of knowledge, power, and sophistication that exists between insureds and insurers is apparent between intermediaries and insureds as well. Intermediaries are more like insurers than insureds: they are repeat players in the insurance industry; they are equipped with expertise, experience and a sophisticated knowledge of insurance; they market products that insureds do not understand; they can exploit this asymmetric possession of information to their advantage. Simply put, insureds have no more savvy, knowledge, or power in the relationship with their intermediary than they do with their insurer.

Despite the imbalances in the relationship between insureds and intermediaries, case law often does not impose a particularly high standard of care upon insurance intermediaries. Usually, courts do not regard these intermediaries as fiduciaries and they are merely held liable under a negligence theory. For some courts, it is the insured who bears most of the risks associated with imperfect communications or failure to purchase appropriate coverage. “[T]he majority of courts have placed the burden on the client to know potential coverages and ask for a particular coverage” rather than “requiring the agent to clarify the request and educate the client.”⁵¹

A few courts have flirted with the notion that intermediaries, particularly independent brokers, may be fiduciaries, on compelling facts⁵²

independent counsel at insurer’s expense in instances of conflict). Even jurisdictions that do not require so-called “Cumis counsel” establish enhanced obligations to govern both the attorney hired by the insurer and the insurer itself. *See* *Finley v. Home Ins. Co.*, 975 P.2d 1145, 1156-57 (Haw. 1998); *see also* *Tank v. State Farm Fire & Cas. Co.*, 715 P.2d 1133, 1137 (Wash. 1986).

⁵¹ Daniel Gregory Sakall, Note, Can the Public Really Count on Insurance Agents to Advise Them? A Critique of the “Special Circumstances” Test, 42 ARIZ. L. REV. 991, 1002 (2000).

⁵² *See, e.g.,* *Watkins v. HRRW, LLC*, No. 3:05-00279, 2006 WL 3327659 at *8 (M.D. Tenn. Nov. 14, 2006) (a broker may be a fiduciary “if Plaintiff establishes that: 1) that the transaction was not an ordinary arm’s length, business transaction; and 2) that the particular facts establish a confidential relationship had been established” and that to establish a confidential relationship the plaintiff must have “reposed confidence in the agent who exercised dominion and influence to act for the plaintiff’s benefit”).

or for particular tasks.⁵³ Only a handful of jurisdictions have characterized the broker relationship generally as fiduciary.⁵⁴ Arizona has adopted a professional standard of care, that requires brokers to “exercise reasonable care, skill and diligence in carrying out the agent’s duties”⁵⁵

In spite of a handful of notable attempts to classify insurance intermediaries as either professionals or fiduciaries, in most cases absent a so-called “special relationship,” the only duty the intermediary actually

⁵³ See, e.g., *Highlands Ins. Co. v. PRG Brokerage, Inc.*, No. 01 Civ. 2272 (GHB), 2004 WL 35439 at *6 (S.D.N.Y. Jan. 6, 2004) (noting that in New York, a broker is a fiduciary in narrow circumstances, specifically collecting and receiving premiums); see also *Philips v. State Farm Mut. Auto. Ins. Co.*, 497 S.E.2d 325, 327 (N.C. Ct. App. 1998) (insurance agent is a fiduciary for the insured “with respect to procuring insurance, correctly naming the insured in the policy, and correctly advising the insured about the nature and extent of his coverage” but has no fiduciary duty to advise insured in the absence of a request).

⁵⁴ Illinois courts view the insured-broker relationship as fiduciary. However, legislation limits broker liability. See *DOD Tech. v. Mesirov Ins. Serv.*, 887 N.E.2d 1, 6 (Ill. Ct. App. 2008) (insured stated a cause of action for breach of fiduciary duty for alleged misappropriation of premiums, an exception to statutory immunity). In New Jersey, a broker’s duties have been characterized as fiduciary:

Further, as a result of the special nature of their relationship, an insurance broker owes a fiduciary duty towards its principal:

Any individual seeking insurance should be able to rely on the expertise of the agent, regardless of the prior contract between the parties. The fiduciary nature of such a relationship should not depend solely upon the length of the relationship. Because of the increasing complexity of the insurance industry and the specialized knowledge required to understand all of intricacies, the relationship between an insurance agent and a client is often a fiduciary one.

In re Payroll Exp. Corp., Bankruptcy No. 92-B-43150 (CB), 2005 WL 2438444 at *17 (Bankr. S.D.N.Y. Mar. 30, 2005) (summarizing New Jersey law and quoting *Sobotor v. Prudential Property & Cas. Ins. Co.*).

⁵⁵ *Sw. Auto. Painting and Body Repair, Inc. v. Binsfeld*, 904 P.2d 1268, 1271 (Ariz. Ct. App. 1995). See Shane Ham, Arizona Case Note, *Webb v. Gittlen: Assignability of Professional Negligence Claims Against Insurance Agents*, 50 ARIZ. L. REV. 647, 650-51 (2008) (observing that Arizona is in a minority of jurisdictions elevating agents to a professional standard of care).

owes the insured is to act reasonably to procure the specific policy the insured requests.⁵⁶ It has proven difficult for insureds to establish that a special relationship in fact existed. “A special relationship in the context of insurance requires more than the ordinary insurer-insured relationship.”⁵⁷ The agent must take some affirmative step to elevate the relationship, such as “hold[ing] himself or herself out as a highly skilled insurance expert, and the insured relies to his detriment on that expertise.”⁵⁸ It may “also be demonstrated by a long term relationship of confidence, in which the agent or broker assumes the duty to render advice, or has been asked to provide advice, and the advisor is compensated accordingly, above and beyond the premiums customarily earned.”⁵⁹

Lewis-Williamson v. Grange Mutual Insurance Co.⁶⁰ illustrates judicial reticence to find a special relationship. There, the plaintiff, a 78-year-old homeowner, had insured her home through Grange Mutual since 1981.⁶¹ Beginning in 1991, plaintiff purchased her insurance through Clute, an agent who wrote “property insurance exclusively for Grange Insurance unless Grange Insurance d[id] not offer the requested insurance, in which case Clute [wa]s authorized to seek coverage from another insurance company.”⁶² In 1996, when plaintiff’s policy limits were \$200,000, she attended a Grange Hall meeting⁶³ and discussed her

⁵⁶ Michael Childress et al., *A Matter of Trust*, 2005 CHI. B. ASS’N REC. 30, 32; Colin Sammon, Comment, *Insurance Agent and Broker Liability: Crossing the Two Way Street*, 29 OHIO N.U. L. REV. 237, 242 (2002); Richmond, *supra* note 33, at 16.

⁵⁷ Sadler v. Loomis Co., 776 A.2d 25, 35 (Md. Ct. Spec. App. 2001).

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ 39 P.3d 947 (Or. App. 2000).

⁶¹ *Id.* at 948.

⁶² *Id.*

⁶³ Grange Hall is a national social and community centered association for farmers with local affiliates in rural communities. Importantly, Grange Mutual is

insurance with Clute after the meeting. According to the court, Grange Insurance was only available to Grange members and Clute discussed insurance needs with members after the Grange meetings.

Plaintiff asked Clute to increase her insurance “to at least double” and that she wanted “replacement cost.”⁶⁴ Focusing on the “casual nature of the relationship,” the court observed that Clute told plaintiff he would “stop by,” but did not make a formal appointment with her.⁶⁵ Thereafter, Clute did stop by when she was not there, and examined only the exterior of her home. Intimidated by a large dog, Clute did not fully inspect the home.⁶⁶ Nevertheless, Clute did provide the plaintiff with advice. “Based on his exterior inspection and a telephone conversation with plaintiff, Clute recommended to plaintiff that she increase her coverage on the residence to \$510,000.”⁶⁷ Plaintiff followed his recommendation.

In 1998, plaintiff’s residence was completely destroyed and replacement costs were estimated at \$700,000, well in excess of the insured value.⁶⁸ Plaintiff filed a negligence action against Clute, and against Grange on vicarious liability. The court granted summary judgment in favor of both defendants, and the Oregon Court of Appeals affirmed.⁶⁹

The court explained that, absent a special relationship, “an insurance agent acting as an agent for the insured owes a general duty to exercise reasonable skill and care in providing the requested insurance.”⁷⁰

an insurer that focuses on the insurance needs of rural and farm communities. HOOVER’S BASIC CO. REC., GRANGE MUTUAL CASUALTY COMPANY (2009); *see also* Malcolm Trupp, *Locally, Granges Thriving*, THE REGISTER GUARD, May 20, 2008, at A7.

⁶⁴ *Lewis-Williamson*, 39 P.3d at 950.

⁶⁵ *Id.*

⁶⁶ *Id.* at 948.

⁶⁷ *Id.*

⁶⁸ *Id.* at 949.

⁶⁹ *Id.* at 948-49.

⁷⁰ *Lewis-Williamson*, 39 P.3d at 949.

The court acknowledged that plaintiff placed trust in Clute to advise her, but distinguished between the factual trust plaintiff placed in Clute and trust establishing a legal obligation to act in her interest. “The fact that she trusted him and deferred to his judgment does not make him her agent or show that he was acting on her behalf.”⁷¹ The court continued, “[a]lthough plaintiff trusted Clute to take care of her insurance needs, there is no evidence that she had reason to expect, other than through her trusting nature, that he would work on her economic behalf.”⁷² The court noted that as a captive agent, Clute was Grange’s agent, not hers, and had “been available to her for her convenience by virtue of his presence at Grange Hall meetings, but that was for the economic benefit of Grange and himself and not plaintiff.”⁷³

The result is troubling. A 78-year-old homeowner purchased an inadequate amount of insurance through a mutual insurer who particularly catered to rural clients, whose captive agent had purposely cultivated a lengthy and trusted relationship, and who affirmatively offered faulty advice. Yet in the court’s view the insured was not reasonable to trust Clute’s advice.⁷⁴

⁷¹ *Id.* at 950.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ The plaintiff would have been better off if Clute had advised her to obtain an appraisal of the cost of replacement, rather than to suggest an amount. Had he not wanted her to follow his advice, he could have easily warned her that it was merely his own personal opinion or better yet, not rendered any advice at all.

Canales v. Wilson Southland Ins. Agency, 583 S.E.2d 203 (Ga. Ct. App. 2003), is equally disturbing. Canales, a customer of independent agent Wilson for several years, sought automobile insurance to cover his vehicle in both the United States and Mexico. Canales did not speak English, and brought an interpreter with him to the insurance agency. After the insured vehicle was destroyed in Mexico, the insurer denied the claim because driving in Mexico was excluded from coverage. Canales filed suit against Wilson claiming Wilson did not procure the proper insurance for Canales. At summary judgment, the fact of whether Wilson expressly said the automobile policy would cover trips to Mexico was hotly contested. Both the interpreter and Canales claimed Canales requested Mexico coverage and that Wilson said the policy would cover driving in Mexico, while Wilson denied the alleged statements. *Id.* at 204. On the other hand, it was

B. THE DISCONNECT BETWEEN THE COMPLEXITY OF THE
PRODUCT AND CURRENT STANDARDS FOR INTERMEDIARY
LIABILITY

Lewis-Williamson illustrates the majority rule that, absent “special circumstances,” little is owed by an insurance intermediary to the insured. It further illustrates judicial reluctance to find that special relationship, even on quite compelling facts. This approach does not appropriately account for the level of trust commonly placed in intermediaries or the lack of sophistication and expertise common to insureds.⁷⁵ Insurance intermediaries are generally viewed as a sales force for insurers and “something less than professionals”⁷⁶ by the courts,⁷⁷ despite the importance and complexity of the product they sell.⁷⁸ While courts may

undisputed that Canales, who did not read English, did not read the policy issued nor have his interpreter read it to him. Canales also claimed that he relied on Wilson to obtain appropriate insurance, that he trusted Wilson to advise him, particularly because of their prior dealings and because Canales was unsophisticated in matters of insurance. *Id.* at 204-205. Despite the contested facts regarding what was said, Wilson obtained summary judgment, because the language of the policy issued was clear and Canales had a duty to read the policy or have someone read it to him. *Id.* The court observed, just because “two people...have come to repose trust and confidence in each other as a result of such dealings is not sufficient, in and of itself, to warrant a finding that a confidential relationship exists between them.” *Id.* at 205 (quotation marks omitted).

⁷⁵ The special circumstances exception that many jurisdictions adhere to requires the plaintiff insured to establish something more than an ordinary broker-insured relationship, i.e., a factual basis for a heightened standard of care imposed on the intermediary. See Richmond, *supra* note 33, at 27-28 (describing instances where courts have found a special relationship). Yet, even when confronted with special circumstances, courts seem reluctant to find the exception applies. As Richmond observes, “special relationships are not lightly created.” *Id.* at 27.

⁷⁶ Sakall, *supra* note 51, at 1004.

⁷⁷ *Id.* at 993.

⁷⁸ Sakall, surveying approaches adopted by courts observed that the standard of care set by courts is inappropriately low, and the special circumstances test unwieldy. He argued that an Arizona approach is preferable. Under Arizona

not regard intermediaries as professionals, intermediaries commonly market themselves as professionals with expert knowledge that consumers can trust.⁷⁹

Paradoxically, courts frequently have imposed unrealistically high expectations on insureds in these transactions: to read and understand an insurance policy, and to understand and communicate precisely their own insurance needs.⁸⁰ Insureds, both commercial and individual, are expected to carefully research the purchase of insurance as they would the purchase of any commodity, including checking with multiple sources and comparing prices and benefits.⁸¹ Caveat emptor applies to the procurement

caselaw, Sakall explains that the duty of agents may include a duty to advise. He writes:

The Arizona approach is preferable to the majority's "special circumstances" test for a number of reasons. First, agents' duties do not turn on whether they are company agents or brokers. All insurance agents are held to a general professional duty. Second, an agent's liability turns not upon some dictate by the court but, rather, upon the conduct of the agent's colleagues and a jury's determination. If both their colleagues and a jury believe it reasonable for an agent not to have advised a client, the agent will not be found liable. Third, agents gain some certainty in knowing that they must keep up with industry customs rather than hoping that a judge does not create some new type of "special circumstance." Fourth, courts are open to clients who truly entrust their insurance concerns to their agents and seek their agents' advice. Fifth, the Arizona approach does not decrease judicial efficiency, as the "special circumstances" rule still requires a jury trial before the judge can determine whether a duty exists. Finally, if a client's damages are limited to the policy limits of a policy that should have been recommended, there is no danger of subverting the fundamental purpose of insurance in allocating risk.

Sakall, *supra* note 51, at 1013.

⁷⁹ *Id.* at 1011.

⁸⁰ In this regard, both sophisticated commercial insureds and unsophisticated consumer insureds fare similarly. *See, e.g.,* Wilmering v. Lexington Ins. Co., 678 S.W.2d 865, 872 (Mo. Ct. App. 1984) (finding no duty of insured's broker to advise or explain "watchman" warranty to an insured corporate owners of a river vessel purchasing marine insurance). In my view, Richmond also has unrealistically heightened expectations of insureds. *See* Richmond, *supra* note 33, at 33 ("[c]ommerical insureds are keenly attuned to deductible amounts and issues").

of insurance.⁸² Notably, the brokerage houses involved in the Spitzer investigation dealt with large commercial insureds. Yet even these highly sophisticated insureds were unable to discern whether they were obtaining the services they needed at a fair price. It begs the question, if even business savvy commercial insureds are unable to protect their interests, how can we expect personal insurance consumers to guard against their agents' undisclosed financial motives without safeguards?

Judicial reluctance to impose a professional standard of care on intermediaries ignores the realities that insurance products are so complex, the customers so unsophisticated, and the bargaining aspects so one-sided that insureds deserve special advantages to level the field. The market for intermediaries exists because of the complexity and incomprehensibility of insurance policies. Even sophisticated insureds must seek the counsel and advice of an intermediary to understand what they are purchasing.⁸³ Nevertheless, despite the fact that courts understand the vulnerabilities of the insured and protect them in other aspects of the insurance transaction, they neglect a principled approach of imposing a professional standard of care on intermediaries. A heightened standard of care better protects insureds and acknowledges the trust intermediaries nurture, expertise they possess, and the advice they provide.

III. INSURANCE INTERMEDIARY COMPENSATION

On October 14, 2004, then New York Attorney General Eliot Spitzer filed a complaint against one of the world's largest insurance brokers, Marsh and McLennan, alleging that the compensation scheme between it and certain insurance companies constituted fraudulent business practices.⁸⁴ The suit alleged that Marsh improperly steered its customer

⁸¹ Richmond, *supra* note 33, at 12, (citing *Weisblatt v. Minn. Mut. Life Ins. Co.*, 4 F. Supp. 2d 371, 382 (E.D. Pa. 1998)).

⁸² *Id.*

⁸³ Beh, *supra* note 49, at 94, 97-98.

⁸⁴ See generally Fitzpatrick, *supra* note 7, at 3041 (recounting events and repercussions of the New York lawsuits and investigations). See also *In re Marsh ERISA Litigation*, No. 04 Civ. 8157(SWK), 2006 WL 370169 (S.D.N.Y. Dec. 14, 2006). Insurers were also targeted in the Spitzer investigation. For example, Aon

business to insurers in order to take advantage of Marsh's commission structure with these insurers. The suit alleged that the compensation agreements Marsh had developed with key insurers created an incentive for Marsh to steer business to insurers that paid maximum contingent commissions, regardless of whether those insurers offered the most competitive rates to Marsh's clients. The suit raised the question of whether the compensation scheme between insurers and intermediaries created insurmountable conflicts of interest between insureds, insurers, and their intermediaries.⁸⁵

A. CONTINGENT COMMISSIONS

Independent agents and exclusive agents both typically earn compensation through commissions paid by insurers.⁸⁶ Brokers, who are selected by insureds to provide broader risk management assessment than simply placing insurance, earn commissions for the insurance they place, even while charging fees to insureds for other services.⁸⁷

It has been "a familiar and public feature of the insurance market"⁸⁸ to also pay "contingent commissions"⁸⁹ to intermediaries, and it is these

Corporation eventually settled with the State of New York, apologized for participating in contingent commission steering schemes, and established a fund for insured claimants. *See Piven v. Ryan*, No. 05 CV 4619, 2006 WL 756043, at *1 (N.D. Ill. Mar. 23, 2006).

⁸⁵ While attention was largely directed at large commercial brokers, such as Marsh and Willis, in fact contingent commissions were common compensation schemes with brokers of all sizes. Fitzpatrick, *supra* note 7, at 3045, 3056-57.

⁸⁶ *See Cummins & Doherty*, *supra* note 11, at 379. Cummins and Doherty also observe that "[s]ome intermediaries also receive noncash compensation from insurers" to reward "superior performance." *Id.* at 379, n.17.

⁸⁷ Cummins & Doherty, *supra* note 11, at 379.

⁸⁸ Fitzpatrick, *supra* note 7, at 3049.

⁸⁹ *Id.* The practice of paying commissions based upon profitability is not new. *See, e.g., Harris & Spear, Inc. v. Concordia Fire Ins. Co. of Milwaukee*, 68 F.2d 63 (9th Cir. 1933) (describing terms of a 1922 broker contract with an insured: "By the terms of the contract the said general agents or managers were allowed 'a flat

types of commissions, more so than commissions based solely on premiums, that have drawn criticism. Contingent commissions are typically earned based on the intermediary's profitability to the insurer.⁹⁰ "Typically, contingent commissions are based on the profitability of the intermediary's business placed with the insurer, the persistency rate, and/or on the volume of business."⁹¹

Contingent commission compensation structures vary from insurer to insurer, even between intermediaries for the same insurer, and from line to line.⁹² They may be contingent on volume sold, i.e., the intermediary receives a commission based on reaching certain volumes; or they may be profit based, i.e., the intermediary receives a commission based on factors such as claims filed on a policy.⁹³

Contingent commissions reward intermediaries for meeting profit aims of the insurer. Until recently, there was no obligation or practice that encouraged intermediaries to disclose the manner or amount of compensation they earned from the insurer to the insured.⁹⁴

commission of thirty-five per cent of the net premiums written,' and, in addition thereto, 'a contingent commission of fifteen (15) per cent of the net profits of the business under their charge, said profits to be computed as of the 31st day of December, 1923, and annually thereafter on the business of each 'single' year so long as this agreement shall continue."'). An agreement between a broker and an insurer from the 1980's described the contingent commission as based on 25% of the "[n]et underwriting profit" described as "the excess of income to plaintiff [insurance company] over outgo from plaintiff." *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Risk Exchange, Inc.*, No. 86 Civ. 7461 (MJL), 1990 WL 210258 at *1 (S.D.N.Y. Dec. 13, 1990).

⁹⁰ Regan & Tennyson, *supra* note 14, at 648-50.

⁹¹ Cummins & Doherty, *supra* note 11, at 379. *See* Roth v. AON Corp., 2008 WL 65069 at *1 (N.D. Ill. Mar. 7, 2008) ("contingent commissions" refers to a practice in which brokers such as Aon received payments from insurers based on the overall volume or profitability of business that brokers placed with those insurers.").

⁹² Cummins & Doherty, *supra* note 11, at 379.

⁹³ *Id.*

The perceived problem with contingent commissions is that intermediaries earned additional and different commissions based upon where they placed an insured's business.⁹⁵ Some assert that these commissions create an irreconcilable conflict between the intermediary and the insured because the intermediary's self interest in compensation may not be aligned with the insured's interest in obtaining the best insurance for their needs at the best price.⁹⁶ The variability in compensation between insurers and the availability of contingent commissions tend to pit the insured's interests against the intermediary's own financial interests, while the lack of disclosure makes it unlikely that insureds would be able to protect themselves.

Contingent commissions may force the intermediary to choose between their own desire to enhance their income and their responsibility to place the insured with the insurer and policy most ideally suited to meet the insured's needs. This type of commission creates the risk of "steering," where the insured is placed with the insurer that provides the best commission rather than the best policy for the insured.⁹⁷ Contingent

⁹⁴ Douglas Richmond argues that intermediaries do not have any duty to disclose their compensation to insureds. Richmond, *supra* note 33, at 35-36. He argues that the competitive marketplace and other market forces, state regulation, impracticalities, and its attenuated effect on premiums favor a no duty to disclose compensation rule. *Id.*

⁹⁵ The intermediary's value to the insurer is the fact that they own their client lists. "Agent ownership of policy expirations means that the insurance provider has no legal right to solicit an independent agent's clients directly or to replace the agent and assign his customers to another agent." Regan & Tennyson, *supra* note 14, at 640. When a policy is first placed or later renewed, an agent earns a "premium based commission." Cummins & Doherty, *supra* note 11, at 375. This is "a commission which is a proportion of premium volume." Regan & Tennyson, *supra* note 14, at 648. Some insurers only pay premium-based commissions. Cummins & Doherty, *supra* note 11, at 375.

⁹⁶ Schwarcz, *supra* note 3.

⁹⁷ *Id.* at 297. See Jeffrey Wilder, *Competing for the Effort of a Common Agent: Contingency Fees in Commercial Lines Insurance* (U.S. Dep't of Just., Antitrust Div., Econ. Analysis Group, Working Paper No. EAG03-4, 2004), available at <http://irm.wharton.upenn.edu/S02-Wilder.pdf>. The study found that contingency fees affect where brokers place their customers in several ways.

commissions may also serve to limit the intermediary's drive to search for low prices and bargains.⁹⁸ If the intermediary chooses to prioritize "their receipt of contingent commissions over their market-matching role," their customers may receive suboptimal insurance, or a much more expensive policy than their needs dictate.⁹⁹

B. REPONSES TO CONTINGENT COMMISSIONS

Different schools of thought exist regarding the best way to counteract the harmful effects of contingent commissions. Some are convinced that contingent commissions are efficient and do not harm insureds.¹⁰⁰ For those who view contingent commissions as benign, a solution to calm fears is to permit contingent commissions but require

Brokers receiving contingency fees are more likely to place new customers with insurers offering contingency fees, they are less likely to move renewing insureds to non-contingency fee paying insurers, and they are less likely to place customers with insurers "for which contingency fee contracts have been 'swamped' by past losses and are unlikely to pay contingency fees in the current year." *Id.*

⁹⁸ Victor P. Goldberg & Richard A. Epstein, *Introductory Remarks: Some Reflections on Two-Sided Markets and Pricing*, 2005 COLUM. BUS. L. REV. 509, 512 (2005).

⁹⁹ Schwarcz, *supra* note 3, at 878. Recently, an Illinois Appellate Court recognized that an allegation that the broker's undisclosed contingent commissions "led [the broker] to place certain policies for the customer's needs" could state a claim for misappropriation of premiums. *DOD Tech. v. Mesirow Ins. Servs., Inc.*, 887 N.E.2d 1, 8 (Ill. App. 3d 2008). On the other hand, Richmond takes the view that intermediaries have no duty to disclose and that no cause of action for failure to disclose contingent commissions is viable. Richmond, *supra* note 33, at 33. Richmond contends that claims based on a failure to disclose commissions are ill-conceived. *Id.* He writes, "[b]oth agents and brokers are entitled to what the insurance industry considers to be reasonable compensation for their services, even if cost-conscious insureds think otherwise." *Id.* at 36. However, in our view, Richmond does not adequately consider the allegation of self-motivated steering. .

¹⁰⁰ See Cummins & Doherty, *supra* note 11, at 360 ("Although contingent commissions, like most business practices, can be misused by the unscrupulous, in general such compensation plans play an important role in aligning incentives between buyers and insurers and thus facilitate the efficient operation of insurance markets.")

disclosure of the compensation scheme by which they are earned. Proponents of contingent commissions view disclosure as a compromise that would enable insurance customers to make informed decisions.¹⁰¹

Opponents of contingent commission argue that disclosure alone cannot correct the fundamental unfairness in the marketplace that contingent commissions exacerbate. For them, nothing short of banning contingent commissions altogether will suffice.¹⁰² Notably, New York's investigation involved extremely sophisticated insureds, employing and paying for the services of one of the largest brokerage firms in the world. Yet they were unaware of potential conflict posed by contingent commissions or the steering that might or did occur at their expense.¹⁰³ Full disclosure might have helped them to negotiate a clearer deal with their brokers, but only if they had true choices. Arguably, in a concentrated broker market they may not have had choices. Disclosure cannot protect insureds in the consumer or smaller markets, where there is little ability to negotiate a different arrangement. Thus, Schwarcz's position is particularly compelling in the personal lines market.

IV. OTHER INSURANCE INTERMEDIARIES

Insureds at least know that an intermediary is brokering the procurement of insurance; however Professor Stempel writes about intermediaries of whom insureds know far less.¹⁰⁴ These intermediaries are employed by insurers after the contract has been formed and do work on behalf of the insurer. Many of the functions undertaken by these

¹⁰¹ Fitzpatrick, *supra* note 7, at 3067-71 (citing "transparency" as the key to the problem posed by contingent commissions).

¹⁰² Schwarcz, *supra* note 3, at 878.

¹⁰³ Joseph B. Treaster, *Connecticut Suit Says Marsh and Insurer Misled State*, N.Y. TIMES, Jan. 22, 2005, available at <http://www.nytimes.com/2005/01/22/business/22insure.html> ("Clients paid Marsh a fee or commission for unbiased recommendations and, according to the lawsuit, were often unaware of the incentive payments").

¹⁰⁴ Stempel, *supra* note 2, at 741.

intermediaries are those that have traditionally been in-house operational functions, such as underwriting, adjusting, and claim-handling.¹⁰⁵

The issue concerning these intermediaries is not for whom they work or where their loyalties lie. We know that downstream intermediaries work for the insurer. The issue here is whether it better protects insureds and serves the public good to subject these intermediaries to tort liability when their actions harm insureds. If they act as agents for the insurer, is it sufficient that the insured can pursue a claim against that insurer, or would it be advantageous to allow an independent claim against the intermediary as well?

Lack of privity between the insured and these intermediaries generally has made them untouchable, under either tort or third party beneficiary theories. Stempel notes that the prevailing view is that there is not a pressing need to create a cause of action because the insured can adequately vindicate claims by suing the insurer, who should be liable as the principal.¹⁰⁶ He complains that it is unfair to use the barrier of privity to preclude tort liability.¹⁰⁷ After all, in these instances the intermediary usually deals directly with the insured, and even if they are not in privity, the insured is obviously a foreseeable plaintiff. Insulating a tortfeasor for its own conduct toward a foreseeable plaintiff, simply on the grounds of privity, undermines basic tort principles.

Stempel argues that these intermediaries should be subject to potential liability.¹⁰⁸ Among other reasons, he observes that potential

¹⁰⁵ Independent adjusters are independent contractors who work for insurers and self-insurers to investigate and adjust claims. Public adjusters, on the other hand, work for insureds to help them present their claim. *See, e.g.,* Hammill v. Pawtucket Mut. Ins. Co., 892 A.2d 226, 232 (Vt. 2005) (explaining that independent adjusters work “in behalf of the insurer” and public adjuster works “in behalf of insured”); Benjamin v. Thomas Howell Group, No. Civ.1996-071, 2002 WL 31573004, at *2 (D.Virgin Islands Apr. 22, 2002) (explaining that a public adjuster works on behalf of the insured, while an independent adjuster “represent[s] the interests of the insurer”). *See also* NY Adjusters: Who We Are, http://www.nyadjusters.org/Who_we_are/who_we_are.html.

¹⁰⁶ Stempel, *supra* note 2, at 547.

¹⁰⁷ *Id.*

¹⁰⁸ *See id.*

liability to insureds will make intermediaries more directly accountable for their wrongdoing, and that in and of itself advances societal interests. He also notes we cannot count on insurers to always have the ability or incentive to police the conduct of intermediaries who are authorized to act on their behalf, because these intermediaries often function in capacities beyond the tight control of the insurer, operating with some independence and autonomy.¹⁰⁹ The public policy interests that legitimate claims be promptly investigated and paid, and that unfounded claims be denied are better served by holding those who impede those interests to account. Each cog that carries out the functions that facilitate the proper administration of insurance should bear the attendant liability. Finally, insureds here are just as peculiarly vulnerable as they are in all other aspects of insurance transactions. Downstream intermediaries stand between insureds and the insurer who owes a duty to investigate, process, and pay claims honestly and expeditiously. The insured has little power to leverage here, except what power judicially constructed protections can provide.

CONCLUSION

Several dominant themes emerge in the examination of insurance intermediaries that lead to a single conclusion. First, the public knows little about the intermediary who sells them a product or processes or investigates their claims on behalf of insurers. In the case of intermediaries brokering insurance, fundamental questions include: Who does he work for? To whom does he owe his allegiance? Who is paying him? Is he a professional or a salesperson? What recourse is there if he fails to carry out his duties? In the case of downstream intermediaries, similar questions arise, such as: What independent responsibilities and liabilities to the insured does he shoulder for his negligence? That these basic questions are so difficult to answer should compel us to re-think how we regard the intermediary.

The second theme is how relatively low the standard of care is for intermediaries considering the important work they do to facilitate the insured-insurer relationship. The law has established special contract and tort principles to judge the conduct of insurers. It has done so because it recognizes the peculiar vulnerabilities of insureds and strengths of insurers. The insured is just as vulnerable in dealings with intermediaries, and intermediaries share similar strengths with insurers. Intermediaries also

¹⁰⁹ Stempel, *supra* note 2, at 547.

operate in a complex world where insurers and insureds do not share a common language. Intermediaries know a lot about insurance and have an important role in the interface between insureds and insurers but they also have competing interests that are unknown to insureds.

Courts have been champions of insureds when it comes to policing the relationship between insurers and insureds. Courts often favor insureds in the interpretation of insurance contracts; courts construct contractual and tort claims to restrain overbearing conduct, and courts place heightened duties on attorneys who represent insureds at the behest of insurers. Curiously, courts have paid scant attention to the important role of intermediaries in the insurance transaction, and have barely considered whether this is an area that needs judicial vigilance. It is therefore an opportune time for all of us to examine more closely these important and mysterious middlemen and develop a more principled approach.

**THE “OTHER” INTERMEDIARIES:
THE INCREASINGLY ANACHRONISTIC
IMMUNITY OF MANAGING GENERAL AGENTS AND
INDEPENDENT CLAIMS ADJUSTERS**

*Jeffrey W. Stempel**

This article addresses the “other” intermediaries involved in the administration of insurance policies, specifically “downstream” intermediaries, who are engaged in the administration of insurance claims. The focus is on managing general agents, third-party administrators and independent contractor claims adjusters, who perform the nuts-and-bolts tasks of the insurance industry, and are generally less well compensated than commercial insurance brokers. Since these “other” intermediaries are immune from judicial claims by policyholders, they are also less incentivized to perform their duties well. The article argues that, in order to improve the claims process, the “other” intermediaries should be held accountable for their misconduct, at least in tort, or even for “bad faith” in the manner of an insurer. It reviews the benefits of accountability and suggests a workable standard for intermediary liability where an intermediary is potentially liable when a policyholder has alleged negligence or some greater wrongdoing.

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I. INTRODUCTION

As a result of headline-grabbing investigations regarding commissions, the role and conduct of major insurance brokers has received prominent attention in the news¹ and also in the academy.² In this Symposium, Professor Daniel Schwarcz continues his scholarly inquiry on

¹ See, e.g., Ian McDonald, Marsh, Spitzer Settle with \$850 Million, An Apology to Clients, WALL ST. J., Feb. 1, 2005, at C1; Monica Langley & Ian McDonald, Marsh Averts Criminal Case with New CEO – Resignation and Shift On Business Model Reflect Pressure of Spitzer Probe, WALL ST. J., Oct. 26, 2004, at A1; Monica Langley & Theo Francis, Policy Matters: Marsh Probe May Be Tip of U.S. Insurance Scandal – As Spitzer Broadens Inquiry Into Bid-Rigging, Rivals Like Aon are Felling Heat, WALL ST. J. EUR., Oct 18, 2004, at A1; Theo Francis, Spitzer Charges Bid Rigging in Insurance - Top Broker, Major Firms Named in Legal Actions; 'Trust Me: This Is Day One', WALL ST. J., Oct. 15, 2004, at A1. See also Kulbir Walha & Edward E. Filusch, Eliot Spitzer: A Crusader Against Corporate Malfeasance or a Politically Ambitious Spotlight Hound? A Case Study of Eliot Spitzer and Marsh & McLennan, 18 GEO. J. LEGAL ETHICS 1111 (2004-2005) (concluding that Spitzer's use of the media, although questionable on fairness grounds, violated no rules of attorney professional conduct); Stacy Anderson, Developments in Banking and Financial Law: 2004, 24 ANN. REV. BANKING & FIN. L. 1, 94 (2005) ("New York Goes After the Insurance Industry"). Former Attorney General and Governor Spitzer's assessment of the practice of undisclosed contingent commissions is reflected in the title of a press release. See Press Release, Office of New York State Attorney General Eliot Spitzer, Investigation reveals Widespread Corruption in Insurance Industry (Oct. 14, 2004), available at http://www.oag.state.ny.us/media_center/2004/oct/oct14a_04.html. Ironically, Spitzer later would resign the governorship in disgrace after an embarrassing tryst with a very expensive prostitute that raised the prospect, later dropped, of criminal prosecution. See Tom Precious, No Charges for Spitzer in Probe of Prostitution; Federal Prosecutors Conclude Investigation, BUFF. NEWS, Nov. 7, 2008, at A1; Michael M. Grynbaum, Spitzer Resigns as N.Y. Governor; Fierce Enforcer of Ethics is Brought Down by Sex Scandal, INT'L HERALD TRIB., Mar. 13, 2008, at 1.

² See, e.g., Sean Fitzpatrick, *The Small Laws: Eliot Spitzer and the Way to Insurance Market Reform*, 74 FORDHAM L. REV. 3041 (2006); J. David Cummins & Neil A. Doherty, *The Economics of Insurance Intermediaries*, 73 J. RISK & INS. 359 (2006). For a pre-Spitzer scholarly examination of the issue, see Laureen Regan & Sharon Tennyson, *Agent Discretion and the Choice of Insurance Marketing System*, 39 J.L. & ECON. 637 (1996).

this topic,³ continuing to make common sense regarding the limits of permissible broker compensation and the wisdom of regulation of broker commissions. His suggestion in this symposium, that hidden or contingent commissions are more of a problem for consumer insurance than for commercial insurance, seems to me unassailable.⁴ As Schwarcz argues persuasively, the problems presented by undisclosed contingent commissions in the world of commercial insurance brokerage are magnified in the context of consumer insurance purchases. Defenders of commercial brokerage contingent commissions have generally had the weaker of the argument in general. Applied to consumer insurance purchases, the defenses-cum-apologies for traditional contingent commissions seem even more wanting.

Reviewing the law of insurance intermediary liability, Professor Hazel Beh concludes “that courts frequently impose a relatively low standard of care toward insureds upon intermediaries.”⁵ She also finds that “traditional principles of agency law do not provide a particularly helpful framework to understand the legal relationships among insured, insurer, and their intermediaries because the intermediary’s role is inconstant.”⁶ The insurance intermediary is a different type of agent, one that not only is the assigned arm of a primary principal but also has duties to another party to the transaction and is subject to public interest considerations generally surrounding the insurance industry.

Rather than echoing Professor Schwarcz’s compelling critique of the pitfalls of traditional broker compensation or Professor Beh’s insight regarding the limits of traditional agency law as applied to insurance intermediaries, this article addresses the seemingly overlooked “other” intermediaries involved in the administration of insurance policies. Rather than focusing on the “upstream” intermediaries involved in the sale of insurance policies, this article concentrates on “downstream” intermediaries involved in the administration of insurance claims. In

³ See Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL’Y REV. 289 (2007).

⁴ See Daniel Schwarcz, *Differential Compensation and the “Race to the Bottom” in Consumer Insurance Markets*, 15 CONN. INS. L.J. (forthcoming 2009).

⁵ See Hazel Beh, *Insurance Intermediaries*, 15 CONN. INS. L.J. (forthcoming 2009).

⁶ See *id.*

particular, it addresses the question of whether “downstream” insurance intermediaries should be responsible to policyholders and third parties for errors in claims handling. The primary focus is upon managing general agents (“MGAs”), third-party administrators (“TPAs”) and independent contractor claims adjusters, rather than the legal and medical professionals that could also be characterized as downstream intermediaries in the relationship between policyholders and insurers. This article also touches upon the law’s treatment of other actors commonly involved in the claims process as a useful guide to determining the proper legal governance and liability exposure of MGAs, TPAs and adjusters.

As compared to MGAs, TPAs and independent claims adjusters, commercial insurance brokers, the primary focus of recent scholarship on intermediaries, are the “sexy,” “Hollywood” intermediaries of the insurance business. Figuratively, at least, they eat at the Four Seasons and are fixtures at the industry’s golf outings in Bermuda or other resort destinations, as they schmooze with clients and insurers in search of policy sales. For their efforts, brokers, like Marsh and Aon, are well compensated, often paid six figures in annual base pay for representing a policyholder in search of insurance, as well as typically receiving long-standing (but now occasionally controversial) commissions based on the insurance products they procure for their large, wealthy, prestigious business clients.

In contrast, MGAs, TPAs and independent adjusters are saddled with the decidedly less festive task of underwriting (sometimes), billing, record-keeping, and claims processing: ensuring that the insurance policies for which the brokers have already been well paid are properly administered. In return for shouldering these nuts-and-bolts tasks and potentially alienating policyholders through claims denial or mishandling, these other intermediaries are generally less well compensated, particularly as respects claims adjusting. They are more likely to be wolfing down a Big Mac in the office or on the way to an appointment than lunching in the finer restaurants of a major city.

The comparatively low-budget drudgery of these other intermediaries unfairly masks their importance to the insurance system. Many insurers have “outsourced” substantial parts of their operations, making MGAs, TPAs and independent adjusters *de facto* insurers, at least for purposes of these key tasks related to policy administration and claims handling. Despite their increasing importance, these intermediaries have historically been immune from claims by disgruntled policyholders (or others, including claimants) so long as the insurer for whom they work is

known to the policyholder or there is no formal written contract between the downstream intermediary and the policyholder or other third party.

As a result, these intermediaries have been effectively beyond the reach of judicial regulation while being simultaneously under-regulated by executive branch insurance departments. Faced with reduced incentive to discharge their duties well, the other intermediaries frequently act negligently, recklessly, or even in bad faith, needlessly creating claims imbroglios that could be avoided, minimized, or streamlined.

In the past, legal reluctance to hold these other intermediaries responsible for errors may have been tolerable or even efficient. Today, however, the greater near-autonomous role now shouldered by MGAs, TPAs and independent adjusters demands that they be treated under the law on a par with the insurers they represent. Instead of essentially being immunized from the consequences of their errors, these intermediaries should be held accountable, at least in tort for misconduct even if not for “bad faith” in the manner of an insurer.⁷ Holding these intermediaries more accountable holds at least some promise for improvement of the claims process.

⁷ See *Largest MGAs/underwriting managers*, BUS. INS., Sept. 8, 2008, at 20 (ranking of MGAs shows ten largest to have 2007 premium volume of more than \$5 billion, reflecting the degree to which these intermediaries have become big business.) This article does not address questions of the duties and liabilities owed by “front end” insurance intermediaries generally but instead addressed the “back end” or “downstream” (my preferred term) intermediaries involved in policy administration and claims. See *id.* As noted above, the issue of the degree to which brokers or sales agents may be liable to insurers, policyholders, or others and the standard of care applicable to these “upstream” intermediaries lies beyond the scope of this article. *Id.* In general, both brokers and agents may be independently liable to insurance applicants and policyholders for negligence or misconduct in the performance of their duties even when their actions are not binding on their principals. See, e.g., *Terrain Tamers Chip Hauling, Inc. v. Ins. Mktg. Corp. of Oregon*, 152 P.3d 915, 918 (Or. Ct. App. 2007) (settlement with insurer does not extinguish policyholder’s claim against agent). But see *Bentley v. North Carolina Ins. Guar. Ass’n*, 418 S.E.2d 705, 712-713 (N.C. Ct. App. 1992) (policyholder cannot bring bad faith claim against insurance sales agent because of lack of privity of contract). See also *Londo v. McLaughlin*, 587 A.2d 744, 748 (Pa. Super. Ct. 1991) (by statute, brokers owe duty of good faith to policyholder clients).

II. THE TRADITIONAL DOCTRINE OF INTERMEDIARY IMMUNITY

Just as insurance law is a subset of contract law, the law of insurance intermediary liability is a subset of agency law. The principal is the insurer that hires a downstream agent (the intermediary) to represent it in the administration of the policies it has sold. The agent in turn interacts with the principal's "customers" or policyholders and also represents the insurer in dealing with third parties who make liability claims against the policyholder. A "hornbook" rule of agency law, most authoritatively stated in § 320 of the American Law Institute's RESTATEMENT (SECOND) OF AGENCY and continued in § 6.01 of the RESTATEMENT (THIRD) OF AGENCY, is that an agent for a "disclosed" principal is not itself liable for any acts of the principal.⁸

The law of insurance intermediaries, like insurance itself, is also a subset of contract law. To enjoy contract rights, one must normally have entered into a contract with the entity from which one seeks contract rights. Unless one was in "privity" of contract with the party from which relief is sought, the claimant would ordinarily be barred from relief by the historical

⁸ See RESTATEMENT (SECOND) OF AGENCY § 320 (1958) ("Unless otherwise agreed, a person making or purporting to make a contract with another as agent for a disclosed principal does not become a party to the contract."); RESTATEMENT (THIRD) OF AGENCY § 6.01 (2006) ("When an agent acting with actual or apparent authority makes a contract on behalf of a disclosed principal, (1) the principal and the third party are parties to the contract; and (2) the agent is not a party to the contract unless the agent and third party agree otherwise."). See also 3 C.J.S. *Agency* § 485 (2008) (Ordinarily where the agency is disclosed, a plaintiff entitled to recover is entitled to recover against the principal but not the agent); 2A C.J.S. *Agency* § 365 (2008) (An agent who contracts on behalf of a disclosed principal and within the scope of his authority, in the absence of an agreement to the contrary, or other circumstances showing that he has expressly or impliedly incurred or intended to incur personal responsibility, is not personally liable to the other contracting party, although he may execute the contract in a manner which would otherwise bind him personally, and he need not expressly negate his liability); 12-88 APPLEMAN ON INSURANCE § 88.5 (2d ed. 1996 & Supp. 2008). Because the RESTATEMENT (THIRD) is so recent, the limited case law invoking agency principles to shield insurance intermediaries has been based on the RESTATEMENT (SECOND). At this juncture, RESTATEMENT (THIRD) § 6.01 has been cited by only a handful of courts, with none of the decisions involving liability of insurance intermediaries.

“citadel” of privity of contract, which held that an entity not in contractual privity owed no contract-based duties to an aggrieved party and generally owed no socially imposed tort duties as well.⁹ Although recovery could be premised on a theory that the claimant was a third-party beneficiary of the contract between agent and principal, courts were historically reluctant to give contract rights to any third-party beneficiary not specifically so identified in a written instrument.¹⁰

These hornbook rules became established during the 19th Century as Anglo-American law grappled with the question of the apt extent of liability in a growing, increasingly industrial society. The courts largely accepted, at least implicitly, the proposition that unduly broad imposition of liability would throw too much sand in the metaphorical gears of progress and exact too high a tax on commercial activity. Where a

⁹ See Dan B. Dobbs, *The Law of Torts* § 353 (2000); William S. Prosser, *Hornbook of the Law of Torts* §§ 93, 96-104 (4th ed. 1971). See also Lee R. Russ with Thomas F. Segalla, *Couch on Insurance* § 208:10 (3d ed. & Supp. 2008):

Although there are exceptions, investigators and adjusters working under contract for the insurer are, for the most part, not considered to have sufficient privity with or duty to the insured to be directly and personally liable to the insured. Insureds have a better chance of surviving preliminary dismissal motions by framing their actions as breaches of duty owed to the public at large---torts of various types. Of these, the most likely sources of an actionable duty involve the investigator or adjuster acting in a way that “interferes” with the insured’s relationship with the insurer, or with some other legally protected right of the insured.

For more discussion of basic tort law as a ground for holding claim intermediaries liable to policyholders or claimants, see *infra* text accompanying notes 177-221.

¹⁰ See E. ALLAN FARNSWORTH, *CONTRACTS* § 10.2 (3rd ed. 1999) (historically, third parties generally did not enjoy rights under contract unless contract text expressly indicates that third party was intended beneficiary of contract). See, e.g., *Hudock v. Donegal Mut. Ins. Co.*, 263 A.2d 668, 672 (Pa. 1970) (“Without such a [contractual] relationship, it is impossible for the [independent claims] adjusters to be liable for breach of contract to the insureds.”).

commercial actor was linked to another by contract, this created certain rights. But absent such links, law was reluctant to impose liability.¹¹

In addition, immunity for the agents of disclosed principals could be defended on the ground that an aggrieved party nonetheless had substantial legal rights as against the principal. Imposing liability on the agent of the disclosed principal thus seemed unnecessary. Under a rough cost-benefit analysis, the tacit notion appears to be that although agent liability would provide an additional source of compensation for the injured, it brought with it a greater burden of discouraging socially useful agency activity and encouraging needless expansion of disputes.¹²

Applied to the typical commercial transactions of the era, the traditional rules of privity and agency immunity made sense, at least initially. Consider a sale of goods by Merchant Marley through Agent Cratchett to Consumer Dickens. If it is clear that Cratchett is selling on behalf of Marley, Dickens knows with whom he deals: a ruthless businessman not above cutting corners (who would have an ethical epiphany only after death) and not the fair, guileless agent.¹³ After the sale, if Dickens finds the goods to be substandard, he may sue Marley for relief but generally could not also sue Cratchett, an agent for a disclosed principal who has no contractual privity with Dickens.

Because Cratchett appears not to have had any fault or to have much in the way of autonomy, assets, or insurance (the liability insurance

¹¹ See sources cited *supra* note 9. See, e.g., *Winterbottom v. Wright*, (1842) 152 Eng. Rep. 402. Accord *National Sav. Bank v. Ward*, 100 U.S. 195, 203 (1879). But as Prosser also noted, the “citadel” of privity protecting manufacturers and wholesalers not in direct contract with consumers fell during the first half of the 20th Century as courts permitted product liability claims in cases where a product caused physical injury to its ultimate user. See PROSSER, *supra* note 9, § 97. By contrast, the privity prerequisite to liability has retained considerable force regarding agency issues outside the context of product liability.

¹² See *infra* text accompanying notes 15-22, 122-149 (discussing this rationale in modern cases rejecting liability claims against insurance intermediaries).

¹³ Although Dickens presumably did not know *ex ante* that Marley would have a posthumous epiphany (in time to save his partner Scrooge), Dickens famously acquired *ex post* knowledge. See CHARLES DICKENS, *A CHRISTMAS CAROL* (Atlantic Monthly Press) (1843).

industry did not really emerge until after the industrial revolution and was not well-established until the 20th Century)¹⁴ there is not a particularly strong case for permitting him to be sued by Dickens or other dissatisfied customers. Marley is the one responsible for the substandard goods and he should be the one responsible for rectifying things for Dickens. One could argue that making Cratchett liable as well will induce greater care by Cratchett, but this could manifest itself in socially wasteful activity such as Cratchett inspecting the Marley products or standing over the shoulder of Marley’s operations.

Further, as a practical matter, agents like Cratchett with little autonomy are not expected to do much more than be conduits for making a sale and to take orders accordingly. He probably would not be permitted to attempt to provide some quality control to Marley’s operation but would be summarily fired by Marley for his temerity. As this aspect of the hypothetical illustrates, Cratchett in this case is more like an insurance sales or soliciting agent and quite removed in scope of authority from the modern MGA or adjuster, who may have quite a bit of either express or practical authority about the manner in which a claim is resolved.

If instead of being the sales agent, Cratchett were the Complaint Department at Scrooge & Marley, his situation would be closer to that found in modern insurance, at least if Marley had delegated significant authority to Cratchett. In addition, law has subsequently moved substantially in the direction of holding front-end intermediaries such as insurance agents liable under some circumstances, such as when the agent knows of a particular customer’s coverage needs and then procures an inappropriate policy or fails to follow through on a promised purchase.¹⁵

¹⁴ See JOHN FABIAN WITT, *THE ACCIDENTAL REPUBLIC: CRIPPLED WORKMEN, DESTITUTE WIDOWS, AND THE REMAKING OF AMERICAN LAW* (2004) (describing the rise of accident and liability insurance in reaction to increase in injuries associated with industrial revolution); John Fabian Witt, *The Transformation of Work and the Law of Workplace Accidents, 1842-1910*, 107 YALE L.J. 1467 (1997-1998) (also describing the rise of accident and liability insurance in reaction to increase in injuries associated with industrial revolution).

¹⁵ See ROBERT H. JERRY, II, *UNDERSTANDING INSURANCE LAW* § 35 (3d ed. 2002); ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 2.5 (1988). See, e.g., *President v. Jenkins*, 853 A.2d 247 (N.J. 2004) (no duty to advise applicant doctor about gap in coverage where doctor did not advise broker about lapse of prior policy); *Canales v. Wilson Southland Ins. Agency*, 583 S.E.2d 203 (Ga. Ct. App. 2003) (no duty to advise policyholder that auto policy provided no coverage

Consequently, the historical immunity of agents for disclosed principles has begun to look outdated.

When Dickens makes the purchase, there is of course the danger that Marley, a notoriously mean character, will only make good on the contract if sued to judgment or that he might seek to avoid his lawful debts. But Dickens knew he was dealing with Marley and historically was constructively charged with knowing these things about his infamous vender. In addition, the law of debt relief was considerably less favorable to the Marleys of the world at the time that the general rule was crafted. Rather than risk debtor's prison, Marley was likely to pay a court judgment obtained by Dickens. Secreting assets was more difficult as well in a world predating electronic funds transfer, sophisticated corporate shells, and cooperative tropical havens for capital.¹⁶

Under the traditional rules protecting agents, if an insurance policyholder or third party claimant knows that the MGA, TPA, or adjuster is working for the insurer, the MGA, TPA or independent contractor adjuster is generally not itself liable for any misconduct that injures the policyholder or the claimant. The identity of the insurer as principal is almost always disclosed in that the policyholder of course knows that it has insurance with a particular company/principal and the claimant is usually made aware of this by the MGA/adjuster. As a result, under the traditional agency law analysis, MGAs, TPAs and independent adjusters were not held

outside U.S. and Canada). The broker's limited exposure is something of a two-way street. *See, e.g.,* DeHayes Group v. Pretzels, Inc., 786 N.E.2d 779 (Ind. Ct. App. 2003) (insurer lacked special relationship with broker sufficient to require broker to advise insurer that policyholder sprinkler system was inadequate to suppress fire). The agent's potential liability exposure often hinges on the specific facts of a case. *See, e.g.* Harris v. Albrecht, 86 P.3d 728 (Utah 2006) (agent not liable for failing to procure policy where evidence shows that possibility of additional insurance was discussed but policyholder never directed agent to procure insurance); Murphy v. Kuhn, 682 N.E.2d 972 (N.Y. 1997) (insufficient "special relationship" between agent and customer to make agent liable for alleged failure to advise customer regarding "possible additional insurance coverage needs."). Where an agent sells or distributes a merchant's dangerous products, the law long ago removed the shield of contractual privity as a defense to product liability claims. *See infra* text accompanying notes 43-46.

¹⁶ *See* Lynn M. LoPucki, *The Death of Liability*, 106 YALE L.J. 1 (1996-1997).

liable for mishandling of claims, even when their misconduct amounted to bad faith toward a policyholder.¹⁷

Case law concerning this issue is almost uniformly favorable to insurance intermediaries until the late 20th Century. Where an independent claims adjuster or administrator is accused of mistreating a policyholder or otherwise causing injury, the comparatively few reported cases find the intermediary immunized as a matter of law so long as its representation of the insurer was adequately disclosed.¹⁸ That the cases are so few in number suggest that most aggrieved policyholders or claimants may not have even considered a claim against the intermediary or that such claims were quickly dismissed at the trial level and never challenged on appeal.

Ironically, comparatively few of these cases specifically cite *Agency Restatement* § 320.¹⁹ More commonly, decision is based on the absence of contractual privity between the intermediary and the policyholder or claimant,²⁰ although agency concepts are also occasionally

¹⁷ See, e.g., *Egan v. Mutual of Omaha Ins. Co.*, 620 P.2d 141 (Cal. 1979); *Larkin v. First of Georgia Underwriters*, 466 So.2d 655 (La. Ct. App. 1985).

¹⁸ See, e.g., *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973) (defendants other than insurers not liable for alleged bad faith conduct toward policyholder, resulting in dismissal of investigative service hired by insurers, claims adjuster employed by service, law firm representing insurers in claims adjustment, and individual lawyer in firm). “Obviously, the non-insurer defendants were not parties to the agreements for insurance; therefore, they are not, as such, subject to an implied duty of good faith and fair dealing.” *Id.* at 576.

¹⁹ An October 2008 search of the LexisNexis federal and state court database yields fewer than 40 cases citing RESTATEMENT (SECOND) OF AGENCY § 320 (1958) in cases even tangentially involving insurers. Fewer than 15 cases expressly cited § 320 and address the issue of the liability of an intermediary, including both “upstream” sales intermediaries and “downstream” policy administration intermediaries.

²⁰ See, e.g., *Wolverton v. Bullock*, 35 F. Supp. 2d 1278, 1281 (auto policyholder cannot sue independent claims adjuster because “in the absence of a contract between Sentry [adjuster] and Bullock [policyholder], there can be no implied duty of good faith that Sentry would have owed Bullock. This holding is consistent with approaches taken in other jurisdictions.”) (citing cases from Alabama, California, Louisiana, Nevada, Oklahoma, Mississippi, and Pennsylvania as well as Kansas); *Wathor v. Mut. Assur. Adm’rs*, 87 P.3d 559, 562 (Okla. 2004) (TPA owes no duty of good faith and fair dealing to policyholders

invoked,²¹ sometimes without a specific citation to § 320.²² Little consideration is given to the issue of whether the overall context of the

and facts of the case do not permit policyholders to recover against TPA as third-party beneficiaries of contracts between TPA and an insurer); *Natividad v. Alexsis, Inc.*, 875 S.W.2d 695, 698 (Tex. 1994) (holding no adjuster duty of good faith and fair dealing and no special relationship with policyholder absent contract); *Amica Mut. Ins. Co. v. Schettler*, 768 P.2d 950, 957-58 (Utah 1989) (holding there is no adjuster duty of good faith and fair dealing and no special relationship with a policy holder absent a contract); *Scribner v. AIU Ins. Co.*, 647 A.2d 48, 50-51 (Conn. Super. Ct. 1994) (“Although Connecticut recognizes a common law duty of an insurer to act in good faith in the settlement of the claims of its insured, a cause of action for breach of that duty may be asserted only against an insurers. An action for bad faith, therefore, does not lie against a person who is not a party to the contract of insurance, including an attorney.”) (citations omitted); *Larkin v. First of Georgia Underwriters*, 466 So.2d 655, 657 (La. Ct. App. 1985) (holding a homeowner/policyholder alleging breach of contract and bad faith cannot sue independent claims adjuster because no privity of contract between homeowner and adjuster).

In occasional twists of irony, the traditional approach may on occasion prevent insurers from obtaining relief against intermediaries. For example, in *Farmers Alliance Mut. Ins. Co. v. Naylor*, 452 F. Supp. 2d 1167 (D. N.M. 2006), an insurer facing a presumably questionable claim when fire destroyed a furniture store hired an investigator and independent engineer to conduct a cause-and-origin examination of the fire. When these individuals allegedly failed to preserve evidence useful to the insurer’s defense (presumably one based on arson), the insurer sought to hold each personally liable. The individual investigator sought dismissal on the ground that the insurer’s contract was with his employer, an investigation company, and that the insurer had no claim against him. The court agreed, even though the company was a company he had founded and controlled. *See* 452 F. Supp. 2d at 1175-76 (citing RESTATEMENT § 320, as well as noting absence of direct contract between individual investigator and insurer). *See also* *First Specialty Ins. Corp. v. NovaPro Risk Solutions, Inc.*, 468 F. Supp.2d 1321, 1343 (D.Kan. 2007), *see infra* notes 161-176 and accompanying text.

²¹ *See, e.g.*, *LaFontaine v. Mass. Cas. Co.*, No. C05-5059FDB, 2006 U.S. Dist. LEXIS 27137 at *7 (W.D. Wash., April 27, 2006), *aff’d in part, rev’d in part on other grounds*, No. 06-35434, 2007 U.S. App. LEXIS 26392 (9th Cir. Nov. 9, 2007) (independent claims adjuster for disability insurer initially sued by insured, but dropped from the case by mutual consent when defendant adjuster and insurer argued that adjuster was “a disclosed agent of Massachusetts Casualty Insurance Company [because] Washington follows the RESTATEMENT (SECOND) OF AGENCY § 320 (1958)”) (citing *Hopkins v. Anderson*, 766, 502 P.2d 473 (Wash. Ct. App. 1972)); *Am. Ins. Co. v. Material Transit, Inc.*, 446 A.2d 1101, 1105 (Del. Sup. Ct.,

1982) (holding an agent processing insurance premium payments that erroneously misapplied funds resulting in wrongful cancellation of policy not itself liable because it acted as agent for disclosed principal and had no contractual relationship with policyholder).

[I]n making these payment arrangements [payment processor] Montgomery was not acting for itself but was solely acting as the agent of American Insurance. It is established law that an agent for a disclosed principal is not a party to a contract and is not liable for its nonperformance. *Restatement (Second) Agency* §§ 320, 328; 16 Appleman, *Insurance Law and Practice* § 8832 at 459 (1968). Thus, the only parties to this allegedly breached payment contract are American Insurance [insurer] and Material Transit [policyholder]. Montgomery, acting as agent on behalf of a disclosed principal, American Insurance, is not personally liable to third-party, Material Transit, for acts performed within the scope of its authority.

Id. at 1104-105.

See also *WESTRM-West Risk Markets, Ltd. v. XL Reinsurance America, Inc.*, 02 Civ. 7344 (MGC), 2006 U.S. Dist. LEXIS 48769, at *17-*18 (S.D.N.Y., July 19, 2006) (dismissing claim against issuing agent on contract and agency grounds); *Seigworth v. State*, 539 P.2d 464, 466 (Nev. 1975) (holding an individual agent for bail bond company is not liable for bond forfeiture when criminal accused fails to show up for court date). Of course, the agency at issue in *Seigworth* is one of upstream sales agency rather than insurance policy (and a bail bond is an insurance policy or surety arrangement and thus falls outside the scope of this article). However, the short-and-sweet resolution of the question provides a good example of the traditional rule in action.

[W]e now turn to the question, is a bail agent, as attorney-in-fact for the purpose of binding the insurer, himself a surety for the appearance bond?

Unless otherwise agreed, a person making or purporting to make a contract with another as agent for a disclosed principal does not become a party to the contract. *Restatement, Second, Agency* § 320. See also, *Restatement* § 4(1), *Restatement* § 4, Comment (a) and *Restatement* §328.

[In this case,] Resolute Insurance Company is a disclosed principal; Drendel, dba Mac's Bail Bonds is an agent. Drendel cannot be liable for the bond forfeiture.

Id. at 466.

In *WEST-RM*, another case technically involving more of an upstream agency problem than one of policy administration, the federal district court was almost as succinct in applying the traditional rule but held out some ground for possible liability in the future depending on agent activity.

situation creates a relationship for which the law should apply tort law duties of reasonable care.

In addition to fighting this general rule of agent immunity, third party claimants had the additional barrier of the legal rule that an insurer's misconduct in claims administration generally does not create a direct cause of action for the claimant due to the absence of privity of contract and a public policy reluctance to allow such direct actions because of the nature of liability claims in which the insurer is usually charged with

[T]he settled rule in New York is that "when an agent makes a contract for a disclosed principal, it becomes neither a party to the contract nor liable for the performance of the contract. Accordingly, it is not liable if the contract is breached." *Seguros Banvenez, S.A. v. S/S Oliver Drescher*, 761 F.2d 855, 850 (2d Cir. 1985)(citing RESTATEMENT (SECOND) OF AGENCY §§ 320, 328). Although an agent might be held liable on a contract if he acted outside the scope of his agency in executing the contract, [there is no evidence that this occurred and no evidence that the intermediary was subject to the indemnity provisions of the surety bonds in question].

WESTRM-West Risk Markets, Ltd., 2006 U.S. Dist. LEXIS 48769 at *17-*18 (emphasis in original).

²² See, e.g., *Gorab v. Equity Gen. Agents, Inc.*, 661 P.2d 1196 (Colo. App. 1983), in which the Court affirmed a dismissal of a claim against an independent insurance sales agent, but found that its principal, California Union Insurance, could be sued for negligent failure to settle.

Central to the plaintiff's right to recover on these [negligence and breach of contract] claims is the contractual relationship arising from the Cal Union errors and omissions policy. [citation omitted] Since Equity General is the agent of Cal Union, and is not a party to the contract of insurance, it is not bound by duties created under the contract. Accordingly, liability for breach of those duties, whether the breach be contractual or tortious in nature, cannot be visited upon the agent.

Id. at 1198 (citing *Egan v. Mut. of Omaha Inc.*, 620 P.2d 141 (Cal. 1979) and *Iversen v. Superior Court*, 127 Cal. Rptr. 49 (Cal. Ct. App. 1976)). The Colorado Supreme Court subsequently rejected this approach and made adjusters potentially liable for negligent failure to settle in *Cary v. United of Omaha Life Ins.*, 68 P.3d 462 (Colo. 2003). During the intervening 20 years, Colorado caselaw had been edging away from the pure historical rule of agent and intermediary liability set forth in *Gorab*.

defending the policyholder and questioning as necessary the merits of the claim.²³

Bad faith scholar Stephen Ashley adds an additional historical perspective on the manner in which the requirement of contractual privity has insulated insurance intermediaries. In his view, part of the problem is that basing the existence of a bad faith cause of action on a contract's implied covenant of good faith and fair dealing, which was the fulcrum of the modern spurt in first-party bad faith law emerging from California Supreme Court caselaw of the 1970s, resulted in obsessive judicial focus on a formal contractual relationship and privity of contract between the party seeking relief and the actor alleged to have committed misconduct.²⁴

In particular, Ashley views the source of the problem as *Gruenberg v. Aetna Ins. Co.*,²⁵ which he describes as “the landmark case” recognizing “a cause of action for bad faith in first-party cases.”²⁶ *Gruenberg* found that a first-party policyholder (in this case one involving life/health insurance) had bad faith rights vis-à-vis the insurer, which was at the time a novel view, even though bad faith rights of third party liability insurance policyholders had been recognized for several decades.²⁷ However, the

²³ See, e.g., *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58, 61 (Cal. 1988).

²⁴ See Stephen S. Ashley, *Bad Faith Actions: Liability and Damages* §§ 6:09, 6:15 (2d ed. 1997).

²⁵ 510 P.2d 1032 (Cal. 1973).

²⁶ ASHLEY, *supra* note 24, at 6:15. California also launched the modern era of bad faith in the third-party liability context with cases like *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 202 (Cal. 1958) and *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 176 (Cal. 1967). But the widespread emergence of bad faith actions in the first party insurance context did not occur until the 1970s and 1980s. See also Seth William Goren, *Looking for Law in All the Wrong Places: Problems in Applying the Implied Covenant of Good Faith Performance*, 37 U.S.F. L. REV. 257, 268 (2002)(referring to *Comunale* as a “benchmark case”).

²⁷ See, e.g., *Hilker v. W. Auto. Ins. Co.*, 231 N.W. 257, 258-59 (Wis. 1930); *reaff'd on reh'g*, *Hilker v. W. Auto. Ins. Co.*, 235 N.W. 413 (Wis. 1931); *Douglas v. U.S. Fid. & Guar. Co.*, 127 A. 708, 709 (1924). See generally JEFFREY W. STEMPEL, *STEMPEL ON INSURANCE CONTRACTS* Ch. 10 (3d ed. 2006 & Supp. 2009).

The ability of a liability policyholder to sue for bad faith was recognized much earlier than any similar right for first-party policyholders largely because courts viewed the liability policyholder as considerably more vulnerable and dependent upon the insurer since the insurer was controlling the defense of any third-party claims against the policyholder. In particular, courts have seen the insurer and policyholder as part of a defense “team” involving mutual obligations of protection and cooperation, while viewing first-party insurance as something closer to a pure arms-length commercial contract where either party is free to take advantage of the other (although this odd view has fortunately eroded over the past 30 years).

Further, liability claims have the potential to greatly exceed the amount of available insurance if settlement of the claim is not reached and expose the policyholder to potentially bankrupting liability. By contrast, first-part insurance is, at least in theory, supposed to be available in amounts sufficient to provide adequate indemnity once any bad faith wrongs of the insurer have been righted. For example, a homeowner’s policy is likely to be more in sync with property value than may be the case when comparing auto liability policy limits and a serious auto injury claim.

However, the path to modern bad faith law was not necessarily linear or smooth. *Hilker*, cited above, is often viewed as the seminal case of what might be called the early modern era in which liability insurers charged with defending claims against policyholders were held to reasonably rigorous standards of conduct toward policyholders. Prior to *Hilker*, many cases had stated generally that an insurer may not act in bad faith, but, when examined closely, these cases tended to define bad faith as an actual, specific intent to harm the policyholder or outright fraud. This is a more constrained view of bad faith than found in modern cases, which find bad faith where an insurer’s conduct has been non-malicious but unreasonable, insufficiently solicitous of the policyholder’s interests (as opposed to the insurer’s interests) or otherwise deprived the policyholder of the benefit of the bargain embodied by the insurance policy.

For example, in *Best Bldg. Co., v. Employers’ Liab. Assur. Corp.*, 160 N.E. 911 (N.Y. 1928), the court observed:

[t]hat the insurance company in the handling of the litigation or in failing to settle is liable for its fraud or bad faith is conceded and has been repeatedly stated in all the cases bearing on the subject. So also it has been held by this court that the company is not liable on its contract for a failure to settle; a contract imposes upon it no such duty.

[T]here is no implied obligation in the insurance policy in this case that the company must or will settle according to the offer made. * * * The insurance company, in refusing to settle the actions, did what it had the legal right to do under the terms of the policy.”

Id. at 912.

In other words, on the eve of the *Hilker* decision, the bad faith law of New York and most other jurisdictions were relatively toothless in that it did not include the now familiar “duty to settle,” which is not literally a duty to settle under any circumstances and throw money at even frivolous claims, but instead requires that an insurer accept a reasonable settlement offer at or below the available policy limits in cases where there is a substantial risk of an excess verdict that would put the policyholder’s own assets at risk. A significant exception is Texas, which established a duty to settle in *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544, 547-48 (Tex. Comm. App. 1929). Today, the duty to settle in Texas is still routinely labeled the insurer’s “*Stowers* duty.”

The facts of *Best Bldg. v. Employers’ Liab.* created a situation ripe for declaring the existence of a duty to settle, but the New York Court of Appeals showed no interest. An employee was injured and made a claim. The liability insurer, which had a \$10,000 policy limit, defended the claim. The plaintiff offered to settle for \$8,500; the insurer counter-offered at \$6,500 and did not inform the policyholder of the offer or counter-offer. Trial resulted in a judgment of \$16,000 for the injured plaintiff, leaving the employer policyholder understandably upset that it faced \$6,000 of its own liability. Further, the policyholder alleged that it was willing to contribute up to \$2,000 of its own funds to resolve the matter and therefore could have worked with the insurer to effect a settlement had it merely been informed of the offer and counter-offer.

Despite these sympathetic facts, the Court was unmoved, viewing the insurer as having unfettered contract rights to settle or try the case as it saw fit regardless of the consequences to the policyholder. The Court dismissed the bad faith claim as a matter of law. It was not even willing to permit fact-finding and trial regarding the circumstances of the insurer’s seemingly obvious error in failing to resolve a case that resulted in a 160% excess verdict. As long as the failure to settle resulted from mere negligence rather than intent to disserve the policyholder, the insurer was unregulated in this regard, a situation quite different than the norms of modern insurance bad faith law.

By contrast, the Wisconsin Supreme Court in *Hilker* found the negligently unreasonable behavior by the insurer could support bad faith failure to settle claims. The insurer had rejected the injured plaintiff’s settlement offer and responded only with a low offer.

The adjuster for the company exhibited an indifferent and hostile attitude, refusing to meet and discuss settlement in the offices of the attorneys representing the [plaintiff] girl and her father.

[The adjuster and defense counsel] must have known that the testimony of these eye-witnesses of the accident tended to establish actionable negligence on the part of the [defendant and] that the injury was one for which a verdict might be rendered for a sum much in excess of the coverage of the policy. They knew that they had absolute control of the litigation and of its adjustment. They also knew that plaintiff would be liable for all sums in excess of \$5,000 which might be

Gruenberg Court refused to recognize any bad faith cause of action against the independent adjuster involved in the case or the law firm representing the insurer.

Obviously, the non-insurer defendants were not parties to the agreements for insurance; therefore, they are not, as such, subject to an implied duty of good faith and fair dealing. Moreover, as agents and employees of the

recovered in these actions. Under such circumstances the failure to make some more effective effort to adjust the cases does present evidence which sustains the finding that the defendant acted in bad faith toward the plaintiff in handling these claims and conducting this litigation. *Hilker*, 231 N.W. at 260.

As the quotation above might suggest, the first *Hilker* decision left some uncertainty as to whether the insurer's errors amounting to bad faith were negligent or intentional, leading counsel to seek rehearing to clarify the legal standard to be derived from the case. After rehearing and decision a year later, the Court made clear that the insurer's settlement failures need not be willfully intended to injure the policyholder in order to be actionable as bad faith.

[Although it] is the right of the insurer to exercise its own judgment upon the question of whether the claim should be settled or contested . . . the decision should be an honest and intelligent one. . . . In order to be honest and intelligent it must be based upon a knowledge of the facts and circumstances upon which liability is predicated upon a knowledge of the nature and extent of the injuries so far as they reasonably can be ascertained.

This requires the insurance company to make a diligent effort to ascertain the facts upon which only an intelligent and good-faith judgment may be predicated. * * * [I]t should exercise reasonable diligence in this behalf, which means such diligence as the great majority of persons use in the same or similar circumstances. This is ordinary care. *Hilker II*, 235 N.W. at 414-15.

The modern era had arrived regarding duty-to-settle/failure-to-settle bad duties imposed upon liability insurers and it in essence required insurers not to be negligent in their investigation, defense, and settlement conduct regarding a claim against the policyholder. Over the ensuing four decades, third-party bad faith law became more favorable to policyholders in that it generally came to hold that the insurer failing to settle was automatically responsible for the amount of the excess verdict, and also permitted policyholders to seek punitive damages where the insurer's failure to settle went beyond negligence and exhibited willful indifference to policyholder rights. See STEMPEL ON INSURANCE CONTRACTS, *supra*, § 10.06. However, it was not until the 1970s that there was significant recognition of a bad faith cause of action for first-party policyholders faced with unreasonable insurer claims adjustment.

defendant insurers, they cannot be held accountable on a theory of conspiracy.²⁸

To Ashley, the focus on contract as the source of rights to demand reasonable insurer behavior was something of a wrong turn in the law, even though California (in *Gruenberg* and other decisions) and most other states treat breach of the covenant of good faith as a tort, which can subject at least the insurer to a range of compensatory damages as well as punitive damages, at least if it is the policyholder or its proper assignee that is suing the insurer. As Ashley points out, claimants injured by the policyholder seldom have a direct right of action against the insurer that acts in bad faith, a limitation in the law he regards as related to limits on the policyholder's ability to bring bad faith claims against independent adjusters and MGAs.²⁹

My own view is in some disagreement with Ashley in that I see nothing wrong with the basic analysis that has led to the modern establishment of the tort of insurance bad faith in actions by policyholders against insurers. These parties have a contract. The insurance policy contract, like all contracts, carries with it an implied covenant of good faith and fair dealing. But unlike most consumer and commercial contracts, the insurance arrangement and the relationship of insurer and policyholder establish a context in which the meaning of good faith changes (from mere “honesty in fact” to a requirement of reasonable behavior giving equal consideration to the interests of the policyholder) and the covenant of good faith creates tort duties imposed by law on the insurer. The breach of the covenant and those duties correspondingly subjects the insurer that acts in bad faith to tort law damages, including punitive damages if the

²⁸ 510 P.2d at 1039 (quoted in ASHLEY, *supra* note 24, § 6:15).

²⁹ See ASHLEY, *supra* note 24, § 6:15 (*Gruenberg* approach of “reliance on the implied covenant of good faith and fair dealing as the foundation for the tort of bad faith has posed problems for the California courts in determining which persons harmed by an insurer's unreasonable rejection of a claim may sue the insurer for bad faith. The same problems have plagued the courts' efforts to determine which persons responsible for the insurer's unreasonable conduct may be sued for bad faith.”). See also Francis J. Mootz, III, *The Sounds of Silence: Waiting for Courts to Acknowledge That Public Policy Justifies Awarding Damages to Third-Party Claimants When Liability Insurers Deal With Them in Bad Faith*, 2 NEV. L.J. 443, 443 (2002) (arguing in favor of third-party claimant standing to bring bad faith actions against insurer that breaches duty to policyholder to defend/settle claim).

unreasonable behavior is accompanied by a willful indifference to the rights of the policyholder.

This is not a bad syllogism or analysis and provides a sound basis for holding both liability insurers and first-party insurers (property, life, health, disability) liable to policyholders for bad faith breach. Ashley, however, seems to suggest it is an imperfect or even defective analysis because it does not automatically establish standing to sue for bad faith for the third-party complainants themselves or for actions against the downstream intermediaries that administer insurance policies.

From my perspective, Ashley's lament is only partially well-taken. Requiring a sufficiently significant, not-too-attenuated contract connection as prerequisite for bad faith liability makes sense. Failing to do that arguably expands bad faith liability in ways that may prove inefficient and unwise in situations where the claimant is not nearly so vulnerable as the average policyholder suffering a loss or facing a claim.

The failure of the traditional jurisprudence, in my view, is not its presumptive insistence on contract privity or its respect for the disclosed principal rule of agency. The historical approach has become problematic, not because of the contract underpinnings of the bad faith tort, but because too many courts and litigants have seen adjuster liability as an all-or-nothing proposition. Either the adjuster is liable in bad faith, or the adjuster is immune. There is an intermediate position. The adjuster should ordinarily be protected from imputed liability due to an insurer's misconduct, but the adjuster should be liable for negligence (or certainly for more egregious misconduct such as gross negligence or recklessness) based on basic tort principles and overarching agency axioms that overcome the protection provided by the disclosed principle rule.

As discussed below, one need not be in a contract relationship to owe tort duties to third parties and *Agency Restatement (Second)* §320 is really only a rule protecting agents for disclosed principals from being held to the contracts made by the principals through the agent.³⁰ It is not a general tort immunity statute for agents, and courts have erred to the extent they have expanded the Section to have this effect. Picking up on Ashley's critique, I agree that adjusters owe to policyholders the same duty of good faith owed by insurers as principals. Where insurance intermediaries have, in essence, 1) assumed the functions of the insurer (which seems to take place in many MGA and TPA operations, or where adjusters have

³⁰ See *infra* notes 177-221 and accompanying text, proposing and defending tort liability for downstream intermediaries.

substantial discretion in evaluating claims), 2) are in a position of special relationship to a policyholder or other party, or 3) are in a “joint venture” with the insurer, intermediaries should be held to account as if they were the insurer, including facing bad faith exposure.

These downstream intermediaries may or may not owe good faith duties to claimants, depending on whether applicable state law permits claimants to make bad faith claims against a defendant’s insurer. But these downstream intermediaries logically still owe at least tort duties to the claimant, even where the adjuster has more limited discretion. The nature of the intermediary-claimant relationship is one that should impose at least modest duties on the intermediary. Where the intermediary is negligent or reckless and causes injury, the claimant should not be barred from pursuing recompense through tort law.

Currently, because claimants initially and often have styled their claims against adjusters, TPAs, or MGAs as bad faith litigation, the field was shaped by cases like *Gruenberg* that found insufficient contractual connection to impose insurer-like obligations on the intermediaries. So bent, the branch of intermediary liability law grew from simply ruling that intermediaries were not liable to the extent of insurers, to assuming (and least in the seeming majority view) that intermediaries were not liable at all to third parties. But the latter legal rule does not follow even if one strongly accepts the former premise that bad faith liability for downstream intermediaries might be overkill.

In addition, the issue of adjuster or MGA liability has been unduly commingled with the question of whether a third party, such as an accident claimant, can sue an alleged tortfeasor/defendant/policyholder’s insurer for bad faith in claims handling. The overwhelming majority of jurisdictions have refused to permit such claims, reasoning that they induce undue complications and conflicts into the liability claims adjustment process, which requires the liability insurer to defend the policyholder and thus focus its loyalty on protecting the policyholder/defendant rather than pleasing the third party who is suing the policyholder.³¹

For a ten-year period, California permitted such claims per the famous *Royal Globe*³² case, but reversed field in its 1988 *Moradi-Shalal*³³

³¹ See STEMPEL, *supra* note 27, § 10.05.

³² See *Royal Globe Ins. Co. v. Superior Court*, 592 P.2d 329, 332 (Cal. 1979).

³³ See *Moradi-Shalal v. Fireman’s Fund Ins. Cos.*, 758 P.2d 58, 60 (Cal. 1988).

decision. Although neither the California legislature nor the California Supreme Court shows any sign of returning to the *Royal Globe* regime, the intellectual argument on the issue continues. Like many observers, I continue to be relatively ambivalent about any perceived need to give tort plaintiffs and other claimants a direct bad faith right of action against liability insurers. Although scholars have made strong arguments in favor of this extension of the law and advocate *Royal Globe* as the preferred approach,³⁴ courts continue to adhere to the view that bad faith claims against the insurer belong to policyholders and not to tort claimants.³⁵

Judicial opinions on the topic rely not only on maintaining some vestige of the historic citadel of privity but also upon the public policy view that providing third parties with an action for bad faith against insurers would introduce too much mischief into the claims settlement process, likely increasing the costs of the tort system and putting unwise additional demands on the legal system.³⁶ Although these arguments may well be overstated or even wrong,³⁷ they are not merely crabbed, formalistic

³⁴ See, e.g., Francis J. Mootz, III, *The Sounds of Silence*, supra note 29; Francis J. Mootz III, *Holding Liability Insurers Accountable for Bad Faith Litigation Tactics With the Tort of Abuse of Process*, 9 CONN. INS. L.J. 467, 507 (2002); Michael Cohen, Note, *No Faith in Bad Faith*, 41 HASTINGS L.J. 201, 225 (1989).

³⁵ See generally STEMPEL, supra note 27, Ch. 10.

³⁶ See generally *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58 (Cal. 1988).

³⁷ In California, for example, there was a nearly 10-year period in which *Royal Globe* was the law and third-party claimants could directly sue liability insurers for bad faith failure to settle claims against the insurer's policyholders. Needless to say, the world did not end during the ten years in which *Royal Globe* held sway. But see ANGELA HAWKEN ET AL., RAND INSTITUTE FOR CIVIL JUSTICE, THE EFFECTS OF THIRD-PARTY BAD FAITH DOCTRINE ON AUTOMOBILE INSURANCE COSTS AND COMPENSATION 52-53 (2001), available at www.rand.org/pubs/monograph_reports/2007/MR1199.pdf (concluding that the *Royal Globe* rule permitting third party claimants to sue defendants' insurers for bad faith resulted in auto insurance premium increases of more than 10 percent). What cannot be assessed from the Hawken study, however, is the degree to which any increase in premiums may have also purchased more responsible liability insurer/intermediary conduct that both better served claimants and policyholders and reduced costs imposed on the justice system and the taxpaying public.

West Virginia has for many years permitted modified *Royal Globe*-style actions. See *Jenkins v. J.C. Penney Cas. Ins. Co.*, 280 S.E.2d 252, 254 (1981) (permitting a third-party claim against an insurer but requiring that underlying suit against policyholder be resolved first); see also Thomas C. Cady, et. al., *The Law of Insurance Company Claim Misconduct in West Virginia*, 101 W. VA. L. REV. 1, 70 (1988-1999). But this does not appear to be linked to any insurance or economic woes in that state. Further, some states, most prominently Wisconsin, have a direct action statute that permits claimants to sue for statutory rights similar to those available in a common law bad faith action. See Wis. Stat. § 632.24 (2007); see also Wis. Stat. § 632.34 (2007); see also Wis. Stat. § 803.04 (2007). Wisconsin’s insurance situation does not appear to be any more problematic than that of California in the post-*Moradi-Shalal* era or that of other states barring claimant suits against insurers. See also La. Rev. Stat. Ann. § 22:655 (2008); see also La. Rev. Stat. Ann. § 22:983 (2008) (direct action statute); R.I. Gen. Laws § 27-7-1 (2008); see also R.I. Gen. Laws 27-7-2 (2008) (direct action statute). Jerry and Richmond observed:

a few states and territories – Wisconsin, Louisiana, Rhode Island, Puerto Rico, and Guam – have “direct action statutes.” The specific provisions of these statutes vary considerably, but their common characteristics are making the insurer directly liable to the injured party and permitting liability to be established in a single action against the insured and insurer jointly, or in an action against the insurer alone.

See Jerry & Richmond, *supra* note 15, at 628 (footnotes omitted). See also Viqar M. Shariff, Recent Developments, *Grubbs v. Gulf International Marine Co.: The Louisiana Supreme Court Declares the Direct Action Statute Applicable to Marine P & I Insurance*, 68 TUL. L. REV. 1653, 1653-54, 1662 (1994).

Other states, through judicial decision or statute, appear to permit claimant actions for bad faith even in the absence of a classic direct action statute such as Wisconsin’s. See, e.g., *Macola v. Gov’t Employees Ins. Co.*, 953 So. 2d 451, 452 (Fla. 2006) (claimant may bring action directly against defendant’s insurer where there is verdict in excess of policy limits); see also *Hovet v. Allstate Ins. Co.*, 89 P.3d 69, 71 (N.M. 2004) (recognizing *Royal Globe*-type action for auto liability only); *State Farm Mut. Auto Ins. Co. v. Reeder*, 763 S.W.2d 116, 117-18 (Ky. 1988) (interpreting Ky. Rev. Stat. Ann. § 446.070 to permit such actions); Mont. Code. Ann. § 33-18-242 (2005) (making *Royal Globe*-style action available to claimants for failure to attempt good faith settlement after liability has become reasonably clear). The availability in these states of this additional right accorded third-party plaintiffs appears not to have resulted in substantial economic or insurance mischief.

Under these circumstances, critics of the status quo such as Professor Mootz can legitimately argue that the existence of third-party standing to sue for bad faith

assessments dependent upon only the privity of contract notion. It remains difficult (at least for me) to say with certainty whether the traditional view of generally limiting standing to sue for bad faith to insurance policyholders is clearly incorrect or misguided.

In addition, this seems to be an area where the legislative process has produced some positive reaction to a perceived insufficiency of common law judicial remedies for claimants aggrieved by insurer behavior. Nearly all states have some form of Unfair Claims Practices Act and nearly 20 permit third party claimants to sue insurers directly for violations of the relevant state Act.³⁸ In addition, a number of states permit third party claimants to sue insurers directly regarding policy coverage.³⁹

Consequently, limiting common bad faith actions directly against insurers by third-party claimants due to absence of contract privity appears not to be a major defect of modern insurance jurisprudence (although neither does it seem essential to the effective operation of insurance). Some of the same arguments can of course be marshaled in favor of intermediary immunity. But properly assessed, the immunity of

would encourage better behavior by insurers with relatively little negative external costs. But conversely, neither does it appear that the absence of these third-party rights has prevented policyholders and their proxies from enforcing good faith obligations upon insurers. Most commonly, where insurer bad faith occurs in significant degree, the policyholder assigns its potential rights of relief to the claimant and the action is pursued. Although insurers with less vigilant policyholders may “get away” with some bad faith conduct as a result of the status quo, this does not appear to be a gaping hole in the fabric of justice. More potentially troublesome is the U.S. Supreme Court’s recent punitive damages jurisprudence, which as a matter of law has constitutionalized limits on punitive damages that may be imposed upon insurers even for intentional, serious, widespread, and long-standing bad faith conduct. *See* *State Farm Mutual Auto. Ins. v. Campbell*, 538 U.S. 408, 409 (2003); *see generally* JEFFREY W. STEMPEL, *LITIGATION ROAD: THE STORY OF CAMPBELL v. STATE FARM* Chs. 17, 22-23 (2008) (despite considerable evidence of record of insurer’s recalcitrant insistence on treating liability policyholders in bad faith, presumptive maximum punitive damages limited to nine times amount of substantial compensatory awards).

³⁸ *See, e.g.*, *State Farm Mut. Auto Ins. Co. v. Reeder*, 763 S.W.2d 116, 118 (Ky. 1989) (interpreting KY. REV. STAT. ANN. § 446.070 to permit such actions); *see also* MONT. CODE ANN. § 33-18-242 (2005); *supra* note 37.

³⁹ *See, e.g.*, *supra* note 37.

intermediaries is another matter, both in terms of public policy and law. Unfortunately, courts have tended to overly equate the concept of a direct tort victim action against the policyholder's insurer and a policyholder's action against the independent adjuster hired by its insurer.

For example, during the brief reign of *Royal Globe*, California courts appeared to accept the proposition that the state's Unfair Claims Practices Act applied to independent adjusters (and by inference other downstream intermediaries) because these adjusters were in the insurance business within the meaning and purpose of the statute.⁴⁰ However, since *Moradi-Shalal* deposed *Royal Globe*, several California courts have disapproved of these holdings, reasoning that if a third party cannot sue an insurer directly for bad faith, persons without a contract with an adjuster cannot sue the adjuster for bad faith.⁴¹ The California Supreme Court has never resolved the issue and it remains a technically open one in the state, although most observers would probably conclude that the current California Supreme Court is unlikely to permit bad faith suits against

⁴⁰ See, e.g., *Bodenhamer v. Superior Court*, 223 Cal. Rptr. 486, 488-89 (Cal. Ct. App. 1986) (noting that it would “be odd to construe the [Unfair Claims Act] as prohibiting unfair settlement practices by employees of an insurance company but as not prohibiting identical acts when perpetrated by an independent adjuster working for an insurance company” and observing that licensing and regulation of adjusters fell under the auspices of the state insurance commissioner); see also *Davis v. Cont'l Ins. Co.*, 224 Cal. Rptr. 66 (Cal. App. 1986); see also James I. Devitt & Robert C. Hastie, Note, *Independent Insurance Adjusters Liable for Bad Faith: Fair or Farce?*, 64 W. ST. U. L. REV. 229, 233, 235 (1986-1987) (approving *Bodenhamer* and *Davis* results).

⁴¹ See, e.g., *Stone v. New Eng. Ins. Co.*, 39 Cal. Rptr. 2d 714, 730-31 n.26 (Cal. Ct. App. 1995) (“the *Davis* and *Bodenhamer* cases, which extended statutory bad faith liability to independent adjusters, were decided prior to the Supreme Court's decision in *Moradi-Shalal* and are now of doubtful validity”) (citation omitted); see also *Henry v. Assoc. Indem. Corp.*, 266 Cal. Rptr. 578, 585 (Cal. Ct. App. 1990). Even prior to *Moradi-Shalal*, some California decisions resisted holding independent adjusters accountable under the Unfair Claims Practices Act. See, e.g., *Santiago v. Employee Benefits Servs.*, 214 Cal. Rptr. 679, 684 (Cal. Ct. App. 1985); see also *Richardson v. GAB Bus. Servs., Inc.*, 207 Cal. Rptr. 519 (Cal. Ct. App. 1984).

downstream intermediaries by parties not in privity of contract with the intermediary.⁴²

Notwithstanding the conventional wisdom, the assessment that adjuster statutory liability was erased by *Moradi-Shalal* is in my view incorrect, at least if the “third party” suing the adjuster is a policyholder of the insurer that retained the adjuster. Under these circumstances, it is quite clear to the adjuster that it is the representative of an insurer with fiduciary-like duties of good faith to the policyholder and that the policyholder is dependent upon the adjuster’s actions just as it is dependent on the insurer’s actions at a time of substantial vulnerability. A harder question is whether anyone other than the policyholder can lay claim to a statutory cause of action against the adjuster. But in between the extremes of no liability and bad faith exposure to a bevy of third parties, lies the reasonable common law compromise of permitting tort actions in negligence (or perhaps only for greater misconduct) against downstream intermediaries.

As a matter of legal realism, Ashley’s lament that courts have focused too formalistically on privity of contract holds considerable force. Although MGAs and independent adjusters may not have formal contract relations with policyholders or others involved in the transaction, these intermediaries in essence assume the role of the insurer in addressing loss claims. Under these circumstances, courts have been too slow to realize that intermediaries playing this role have also in essence stepped into the shoes of the insurer for these claims and thus logically should be held to the same legal standards governing the insurer. In these cases, both policyholders and other reasonably foreseeable third party claimants should be able to bring claims if injured by the misconduct of the intermediary/insurer.

The problem is not that courts initially focused on the insurance contract and the covenant of good faith in articulating the existence of a bad faith cause of action against insurers. The problem is that courts have been too slow to realize an absence of contract rights hardly answers the question of whether one social actor owes duties to another. An obvious example is simply driving. We have no contract relations with other

⁴² For example, *Stone v. New England Insurance*, discussed in the previous footnote, was authored by Judge Walter Croskey, who is also co-author of the California Practice Guide on Insurance Litigation and an acknowledged authority on the topic. See generally 214 Cal. Rptr. 679; see also WALTER CROSKEY & REX HEESEMAN, CALIFORNIA PRACTICE GUIDE: INSURANCE LITIGATION (2005).

motorists on the road, pedestrians, or bicyclists. But this is not any defense, much less an absolute defense, to our tort liability should we negligently injure any of these persons. The very nature of our activity in relation to these third parties creates duties of reasonable care.

The mistake of courts insisting on independent intermediary immunity is that they have wrongly assumed that the absence of a contract with policyholders not only fails to create contract rights but also erects a shield exempting the intermediary from the ordinary application of tort law. Under accepted tort law principles, claims intermediaries stand in a close relation to policyholders, are in a position to inflict considerable harm on vulnerable policyholders, and are well aware of their substantial power to inflict this harm. Injury to policyholders from wrongful behavior by adjusters is readily foreseeable. Courts have also been too reluctant to recognize that intermediaries assuming the functions of the insurer are a de facto part of that same contract and same covenant that protects policyholders by imposing legal duties on the insurer.

After decades of resisting recognition, courts like *Gruenberg* were finally recognizing what in retrospect seems obvious. A first-party insurance policy creates a special relationship between policyholder and insurer just as does a third-party insurance policy. Further, the first-party policyholder looking to an insurer to pay a property, life, health or disability claim is often just as vulnerable and dependent upon the insurer as is the third-party liability policyholder facing a lawsuit. But having just come to this realization, courts were understandably reluctant to immediately begin making this new action for first-party bad faith available against intermediaries as well as insurers.

Regardless of the issue of contract privity, there still remains the separate issue of whether the intermediary as a disclosed insurer's agent should be immune from tort-based claims for compensation by parties injured from the intermediary's activity. As discussed above, courts have traditionally taken this view but such cases are far less frequent than cases immunizing intermediaries on privity of contract grounds. Infrequent or not, however, this rationale remains one that must be addressed. Further, the agency rationale arguably has a sounder public policy grounding than the lack-of-privity defense to intermediary liability. One can argue with some force that intermediary liability is unnecessary so long as the insurer is itself held accountable for misconduct toward the policyholder. But ultimately the agency immunity rationale, like the lack-of-privity rationale, founders for the reasons set forth in the next section.

A. PROBLEMS OF THE NOW DATED TRADITIONAL APPROACH

Like the citadel of privity itself, the privity defense to agent immunity began to look shopworn over time and out of sync with modern commerce, as did the traditional rule of immunity for the agents of disclosed principals. The story of the fall of the citadel of privity in product liability tort law has been well chronicled in the near-century since the walls began to crumble.⁴³ Although retailers and manufacturers are not strictly in a principal-agent relationship, there are enough similarities to make this development of product liability law analogous to the eroding rationale for insurance intermediary immunity.

In the product liability context, society found retailers selling products that, if defective, could exact substantial injuries on consumers and the public generally. If Marley's products are adulterated and Dickens consumes them after purchase at Cratchett's corner store, an odd variant of the earlier hypothetical illustration occurred. Dickens was injured (physically as well as economically). If he had purchased knowing that Cratchett was but an agent for Marley, he would have a cause of action against the deeper-pocketed Marley. But because the Dickens contract is with Cratchett, traditional contract warranty law and tort law gave Dickens a legal claim only against the more modestly heeled Cratchett.

In a world prior to the widespread sale of commercial general liability insurance, this potentially left Dickens with little hope for significant compensation, unless he was willing to force a sale of Cratchett's assets and potentially remove a well-liked merchant and store from the neighborhood. The real culprit is Marley, purveyor of adulterated products, but under the traditional privity of contract rule, he lay beyond the reach of tort or contract law in any claim by Dickens.

The situation soon proved untenable from a public policy perspective. Once New York Court of Appeals Judge Benjamin Cardozo broke through the formalist barriers to a saner approach in *MacPherson v.*

⁴³ See Dobbs, *supra* note 9, § 353; M. STUART MADDEN, PRODUCTS LIABILITY § 1.2 (2d ed. 1988); see generally William L. Prosser, *The Fall of the Citadel (Strict Liability to the Consumer)*, 50 MINN. L. REV. 791 (1965-1966); William L. Prosser, *The Assault Upon the Citadel (Strict Liability to the Consumer)*, 69 YALE L.J. 1099 (1959-1960).

Buick, the walls of the citadel of privity began to crumble rapidly.⁴⁴ By the middle of the 20th Century, courts were permitting the Dickens plaintiffs of the world to successfully sue the Marley defendants under a theory of consumer product warranty or tort law product liability or both. Manufacturers and wholesalers could no longer hide behind contractual privity. Not only injured customers but often other third parties whose injuries were foreseeable could vindicate their legal rights.⁴⁵

Similarly, retailers like Cratchett were unable to hide behind agency immunity. In operating retail establishments and making sales of products, they were in direct contractual relationships with consumers. They may have been agents of sorts for manufacturers but they were not pure agents acting only as conduits for the principal. They were free-standing contracting parties in their own right. As a result, consumers and the public had available to them a relatively broad scope of potential legal relief against multiple culpable defendants in cases of product liability. Although some may argue that the rights of injured product users are too broad and impose too great a burden on commerce, this legal regime enjoys general acceptance.⁴⁶

⁴⁴ See *MacPherson v. Buick Motor Co.*, 111 N.E. 1050 (1916); see also Prosser, *supra* note 9, § 96; Dobbs, *supra* note 9, § 353 (2000); see generally Prosser, *Fall of the Citadel*, *supra* note 43, at 793.

⁴⁵ See Prosser, *supra* note 9, § 100.

⁴⁶ See Prosser, *supra* note 9, § 100. Dobbs, like other modern product liability scholars, also notes the degree to which perceived problems with the breadth of the mid-20th Century product liability regime resulted in some revision and arguable contraction in the scope of strict liability. Dobbs observes that the RESTATEMENT (THIRD) OF TORTS § 402A (1998):

[D]rops all references to strict products liability. Its view is that courts have mostly come to apply negligence standards in determining design and warning defects, even when they maintained the language of strict liability. The effect, although not the language of the Products Restatement is that strict liability is retained when it comes to product flaws, but negligence or something very much like it, is the test of liability when it comes to design and warning defects.

Dobbs, *supra* note 9, § 353 (footnotes omitted).

Although the Dobbs analysis is correct as to the substantive law of torts, the pro-defendant product liability trends of the past 20 years have not in any

But the arguable flip side of the fall of the citadel of privity has yet to take place regarding insurance intermediaries – at least not completely -- even though the insurance industry arguably has changed in ways paralleling product sales and distribution. Cases today are divided regarding the liability of downstream intermediaries, with the majority clinging to the general rules protecting these intermediaries: privity of contract and disclosed principal grounds.

Until the mid-20th Century, insurers tended to themselves administer the policies they sold. The policyholder was billed for premiums by an insurance company employee. Documentary records were maintained by an insurer employee. When there was a claim (either first-party or third-party), the claim was handled by an insurer employee. This began to change significantly after mid-century as insurers increasingly outsourced policy administration and claims adjustment functions to independent contractors. By the 1980s, even the underwriting and policy placement functions had been outsourced by some insurers. Instead of compartmentalized outsourcing of billing, record-keeping, or claims adjustment, insurers increasingly made use of MGAs, who not only combined these functions but also in essence did the underwriting traditionally performed by insurers.

Some of the wave of solvency problems affecting insurers during the 1980s and early 1990s were blamed on the lax underwriting standards of MGAs, who had an economic incentive to write lots of business (and earn higher fees) while having comparatively less motivation to make sure that the policies were issued to good risks. When the figurative chickens came home to their metaphorical roost, there were a number of prominent insurance insolvencies. Although the solvency problems facing Lloyds of London were primarily rooted in long-tail asbestos and environmental coverage obligations, some of these problems – which led to the form of Equitas in 1996⁴⁷ were also ascribed to overly aggressive underwriting by

appreciable way restricted a potential plaintiff's array of potential target defendants. Manufacturers, wholesalers, distributors, retailers, and installers are all subject to suit by foreseeable product users while the "disclosed principal" and "lack of privity" defenses have generally not been available to defendants.

⁴⁷ See *Lloyd's v. Jaffray*, (1999) Q.B. (Colman, J) (describing background of Lloyd's crisis of early 1990s and formation of Equitas Re); *see generally* ELISABETH LEUSSENHOP & MARTIN MAYER, *RISKY BUSINESS: AN INSIDER'S ACCOUNT OF THE DISASTER AT LLOYD'S OF LONDON* (1995); *see also* Richard J.

MGAs for American insurers reinsured by Lloyd's or involved in risk placement for which Lloyds' syndicates provided excess or umbrella insurance.

My concern in this article is not whether independent contractors like MGAs and independent adjusters are better or worse at their jobs than insurer employees or their respective contribution to problematic insurance practices. My point and contention is much narrower and simpler. For better or worse, these intermediaries have assumed many of the traditional functions of an insurer to a sufficient degree that for most practical purposes, the actions of the intermediary are the actions of the insurer.

Under these circumstances, the traditional citadel of contract privity now seems as outmoded in this situation as it does in the context of product liability. In addition, these intermediaries have morphed from mere agents into the alter ego replacements of insurers, at least as respects their dealings with policyholders and the public. Consequently, a rule of law immunizing them from the consequences of their conduct toward these groups appears increasingly outdated, unfair, and insufficiently deterrent of negligent or wrongful behavior by these intermediaries.

Some of the problem may result from the relative youth of the bad faith cause of action, particularly in first-party cases. Liability insurers have been subject to bad faith claims for as long as 75 years in some jurisdictions. But many states did not solidify this potential exposure until the 1960s or later. First-party bad faith came later, essentially being birthed in the 1970s or later.⁴⁸ When confronted with these relatively new causes of action against insurers, courts were understandably reluctant to expand bad faith liability to entities other than the insurer. Until courts better understood the relatively new tort of insurance bad faith, they were inclined to apply traditional agency and privity of contract rules as a means of regulating the spread of bad faith claims.

Astor, *Lloyd's of London: The Curious Case of Equitas Re*, 23 AM. BANKR. INST. J. 32 (2004).

⁴⁸ See STEMPEL ON INSURANCE CONTRACTS, *supra* note 27, Ch. 10; *see also*, *supra* notes 24-29.

B. THE HALTING MODERN EMERGENCE OF INTERMEDIARY
LIABILITY

As the use of intermediaries increased in the claims process, there was of course a corresponding increase in complaints about the manner in which they performed this function. When denied insurance coverage or victimized by claims handling misconduct, aggrieved policyholders and claimants brought suit against the intermediaries as well as the insurers involved. Although the intermediaries often avoided liability under the traditional immunizing doctrines of lack-of-privity and agent-for-a-disclosed-principal, an increasing number of courts recognized that the nature of the intermediaries' role made it inappropriate to apply the traditional rules.

The first prominent case to expressly impose duties to the policyholder upon an independent adjuster was *Continental Insurance v. Bayless and Roberts, Inc.*⁴⁹ In *Bayless*, the policyholder was sued due to explosion of a "paint pot" it owned that was used by the victim in painting aircraft. The insurer, using an independent adjuster, accused the policyholder of failure to cooperate and threatened to cease defense of the claim unless the policyholder agreed to a reservation of rights. The policyholder "refused to accept such a conditioned defense" and the insurer "withdrew from the case." Left in the lurch,

B&R settled the tort action, agreed to entry of a consent judgment for \$618,000, and then sued [insurer] Continental and its chief adjuster to recover the amount of the judgment as well as punitive damages. The case went to trial and resulted in an award of \$622,000 in damages to B&R, based on the jury's finding that Continental and its adjuster, Arthur Stanford, had negligently conducted B&R's defense, and that the insurance company had breached its duty to defend its insured.⁵⁰

On appeal, the Alaska Supreme Court agreed with the trial court that under these circumstances, the policyholder was entitled to make a bad

⁴⁹ 608 P.2d 281, 288 (Alaska 1980).

⁵⁰ See *id.*, at 283-84.

faith claim against the adjuster, affirming the verdict as reasonable. The unfortunate adjuster found liable (Arthur Stanford) was branch manager of Underwriters Adjusting Company, an Anchorage-based “subsidiary of Continental Corporation” that functioned “as the claims department of Continental Insurance,” which was also a subsidiary of Continental Corporation. Notwithstanding Stanford’s perhaps incestuous relationship with the Continental family, it appears he qualified as an independent adjuster and was not sued in the capacity as an arguable individual employee of the insurer.

The policyholder had successfully accused Stanford of failing to adequately investigate the claim against it as well as failing to inform the policyholder regarding the case, all in breach of an asserted fiduciary duty that demonstrated “gross and wanton disregard” for the interests of the policyholder. Evidence presented at trial suggested that adjuster Stanford had failed to inform defense counsel of problematic facts and had failed to disclose to counsel that the insurer had authorized up to \$10,000 to settle the case.

Relying on *Gruenberg*⁵¹ and *Iversen*,⁵² adjuster Stanford argued that he could not be sued because of his absence of a contractual relationship with the policyholder. Even though *Iversen* had, like *Gruenberg*, generally been viewed as a case tending to immunize intermediaries, the Alaska Court noted that even under *Iversen* a claim for relief could lie, describing *Iversen* as a case in which “[t]he court held that the agent’s liability would depend upon the plaintiff’s theory of recovery.” If the plaintiff was asserting only contractual claims, California law per *Gruenberg* and *Iversen* barred the claims on lack-of-privity grounds and “Stanford could not be held liable for a breach of the fiduciary duty of good faith arising out of the insurance contract” However, intermediaries like Stanford “could be held liable for negligence arising out of a breach of the general tort duty of ordinary care.”⁵³

The *Bayless* Court’s interpretation of California law is open to more than a little debate and appears to have been refuted by the latter state’s continued practice of largely immunizing intermediaries during the

⁵¹ See generally *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (1973).

⁵² *Iversen v. Superior Court*, 127 Cal. Rptr. 49, 50-51 (Cal. Ct. App. 1976).

⁵³ See 608 P.2d, at 287.

ensuing 17 years.⁵⁴ But regardless of whether *Bayless* correctly interpreted California law, it nonetheless provided a beachhead in opposition to the historical view that contract privity and disclosed agency protected TPAs and adjusters. The *Bayless* Court also saw its decision as a natural extension of Alaska law holding that an insurance agent could be liable for negligent failure to provide requested insurance even if the agent was working for an insurance company that was a disclosed principal.⁵⁵

Bayless broke away from the traditional formal rule of adjuster immunity but hardly produced an avalanche of case law rejecting the rule. It would be six years before another state supreme court followed suit. In *Morvay v. Hanover Ins. Cos.*⁵⁶, New Hampshire took a similar approach. The home of the policyholders was destroyed by fire and they sought coverage from their property insurer, which retained an independent investigator to perform a cause-and-origin analysis of the fire.⁵⁷ The investigator subsequently assessed the fire as suspicious, leading to claim

⁵⁴ See, e.g., *Sanchez v. Lindsey Morden Claims Servs., Inc.*, 84 Cal. Rptr. 2d 799, 802-04 (Cal. Ct. App. 1999) (policyholder may not bring claim for injury based on independent adjuster's negligence).

⁵⁵ See *Cont'l Ins.*, 608 P.2d at 287-88 (citing *Austin v. Fulton Ins. Co.*, 498 P.2d 702, 704 (Alaska 1972)). *Bayless & Roberts* remains good law in Alaska but there has not been any particular flood of litigation against adjusters, who appear to remain peripheral to much insurance coverage litigation. See, e.g., *Gibson v. GEICO Gen. Ins. Co.*, 153 P.3d 312, 316-17 (Alaska 2007) (affirming trial court decision to prohibit discovery directed at independent adjusters in policyholder's underinsured motorist claim made against her insurer). Oddly, the policyholder claimed only that she was owed additional UIM benefits from the insurer after having received \$50,000 policy limits "plus \$12,747.50 in add-ons" under the tortfeasor's coverage and did not allege bad faith against the insurer, which presumably would have opened the door to discovery from adjusters. *Id.* at 314. The policyholder prevailed at trial, but only to the tune of a few thousand dollars. *Id.* at 315-16. The opinion has an air of trying to put the case to bed and some annoyance with the policyholder (or counsel's) insistence on prosecuting a case of such limited magnitude.

⁵⁶ 506 A.2d 333 (N.H. 1986).

⁵⁷ *Id.* at 333.

denial by the insurer.⁵⁸ The policyholders sued the investigator as well as the insurer, alleging negligence in the conduct of the investigation.⁵⁹

The trial court accepted the investigator’s defense of lack-of-privity and dismissed the claim.⁶⁰ The Supreme Court reversed, finding that an investigative agent of an insurer conducting a claim investigation owed a duty of good faith to the policyholder “arising out of the [insurance] company’s duty of good faith and fair dealing.”⁶¹ The Court bolstered its determination by noting that investigators were required to be licensed and were subject to a “general duty to use due care” in the performance of their work.⁶²

In addition, the Court noted that existing precedent had held a bank responsible to a beneficiary with which it had no contract for failing to establish a survivorship account requested by the bank’s customer.⁶³ A contractual tie was not necessary to create duties in that case because the bank was aware that the beneficiary would be harmed from negligent discharge of the bank’s contractual duties.⁶⁴ Although the investigative agency and the individual investigator were not in privity with the plaintiffs,

[T]hey were fully aware that the plaintiffs could be harmed financially if they performed their investigation in a negligent manner and rendered a report to [the insurer] that would cause the company to refuse payment to the plaintiffs. [They] were also aware that there was a mutual duty of fair dealing between [the insurer] and the plaintiffs.

⁵⁸ *Id.* at 334.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Morvay*, 506 A.2d at 334.

⁶³ *Id.* at 334-35.

⁶⁴ *Id.* (citing *Robinson v. Colebrook Guar. Sav. Bank*, 254 A.2d 837, 839 (N.H. 1969)).

Under these circumstances, we hold that the plaintiffs have stated a cause of action in negligence [against the investigator and the employee.]

. . . .

. . . Although . . . the investigators may give reports only to the insurer, the insured is a foreseeably affected third party. . . . Both the insured and the insurer have a stake in the outcome of the investigation. Thus, we hold that the investigators owe a duty to the insured as well as to the insurer to conduct a fair and reasonable investigation of an insurance claim and that the motion to dismiss should not have been granted.⁶⁵

The *Morvay* Court also analogized the liability of the investigator to that of accountants, who “are liable in an action sounding in negligence to that group of persons who foreseeably may rely on the accountants’ work.”⁶⁶ Consequently, “accountants may be held liable to persons with whom they are not in privity if they perform their work negligently and the plaintiffs are within the class of persons who could have reasonably relied on the accountants’ work product.”⁶⁷ Without actually articulating the connection, the Court had implicitly put the relatively new wine of claims intermediary liability in the old skin of liability for misconduct that causes foreseeable injury to a known person or class of persons, something that had been part of the majority rule regarding public accountant liability for more than 50 years⁶⁸ and was also part of the accepted approach to the

⁶⁵ *Id.* at 335 (citing *Cont’l Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 287-88 (Alaska 1980)).

⁶⁶ *Id.*

⁶⁷ *Id.* (citing *Spherex, Inc. v. Alexander Grant & Co.*, 451 A.2d 1308, 1312 (N.H. 1982)).

⁶⁸ See RESTATEMENT (SECOND) TORTS § 552 (1977) (auditor liable to foreseeable users of audit for negligence). See, e.g., *Nevada Nat’l Bank v. Gold Star Meat Co., Inc.*, 514 P.2d 651, 654 (Nev. 1973); *M. Miller Co. v. Central Contra Costa Sanitary Dist.*, 18 Cal. Rptr. 13, 15 (Cal. Ct. App. 1961). But see, *Ultramares Corp. v. Touche*, 174 N.E. 441, 444-45 (N.Y. 1931) (limiting auditor

liability of attorneys preparing instruments upon which non-clients would rely.⁶⁹

Although the New Hampshire Supreme Court was potentially casting a very broad net of liability that included not only the entity involved in claims processing, but also individual employees working on a matter, it placed some practical theoretical limits on its expansion of intermediary liability.

[T]he scope of the investigators' duty must be determined in the light of their contract with the insurer. The investigator who contracts to perform a \$200 investigation is not obligated to expend the same effort that might be reasonable for a fee of \$2,000, nor is an investigator obligated to continue an inquiry when the insurer instructs him to stop. The investigator's obligation is to exercise reasonable care in performing the work within the limits set by the insurer and to advise the insurer in the event that the investigator has reason to believe that the investigation is too limited to form the basis for a reliable conclusion.⁷⁰

In essence, the *Morvay* Court was making the common sense conclusion that where a claims intermediary was acting as a surrogate or alter ego of the insurer, liability was likely to follow. But where the intermediary's role and authority were limited, the traditional defenses of lack of contractual privity and disclosed agency would likely continue to have force in apt cases.

After *Morvay*, it would be another five years before another state supreme court spoke in favor of the potentially emerging modern rule. Then, in *Bass v. California Life Insurance Co.*, Mississippi affirmed the general rule that the policyholder could not sue an independent adjuster for

liability for negligence to situations where auditor is not in contractual privity to injured party).

⁶⁹ See RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 51 (2000); *Greycas, Inc. v. Proud*, 826 F.2d 1560, 1565 (7th Cir. 1987) (applying Illinois law).

⁷⁰ *Morvay*, 506 A.2d at 335.

simple negligence, but then broke ranks with the historical norm by also holding that a cause of action would lie if the independent adjuster had acted with gross negligence, malice, or reckless disregard for the rights of the policyholder.⁷¹ However, the adjuster must have sufficient independent authority to make it more than simply an appendage of the insurer. If the adjuster lacks authority to rule on claims without insurer approval, the traditional rule of no intermediary liability still obtains.⁷²

Additional support for the modern approach accelerated during the 1990s. Courts in New Jersey,⁷³ Georgia,⁷⁴ and Nevada⁷⁵ as well as some federal decisions⁷⁶ endorsed the view that intermediaries with substantial insurer-like duties and autonomy could be liable for bad faith or other misconduct toward the policyholder. In the 21st Century, Oklahoma

⁷¹ 581 So.2d 1087, 1090 (Miss. 1991) (citations omitted).

⁷² See, e.g., *Ironworks Unlimited v. Purvis*, 798 F. Supp. 1261, 1265-66 (S.D. Miss. 1992) (acknowledging that *Bass* is controlling state law but distinguishing the instant case because the independent contractor adjuster lacked autonomy of adjuster in *Bass*). In a tangentially related development indicating relaxation of historical doctrine favorable to intermediaries, Pennsylvania held that brokers owe a duty of good faith and fair dealing rather than merely a duty of reasonable care. See *Londo v. McLaughlin*, 587 A.2d 744, 747 (Pa. Super. Ct. 1991).

⁷³ See *Miglicio v. HCM Claim Mgmt. Corp.*, 672 A.2d 266, 273 (N.J. Super. Ct. Law Div. 1995). Regarding the rather complex web of bad faith and related liability in Pennsylvania, see Goren, *supra* note 26, at 276-81.

⁷⁴ See *Gardner & White Consulting Servs., Inc. v. Ray*, 474 S.E.2d 663, 665 (Ga. Ct. App. 1996).

⁷⁵ See *Albert H. Wohlers & Co. v. Bartgis*, 969 P.2d 949, 960 (Nev. 1998).

⁷⁶ See, e.g., *Wolf v. Prudential Ins. Co. of Am.*, 50 F.3d 793, 797-98 (10th Cir. 1995) (applying Oklahoma law) (finding a requisite special relationship existed between the medical plan beneficiary and the plan administrator where the administrator performed many of the tasks of insurer). *Wolf* not only correctly predicted the path of Oklahoma law but influenced it in that subsequent state decisions were persuaded by the reasoning of the *Wolf* court.

adopted this approach,⁷⁷ as did Colorado, specifically disapproving contrary precedent from the 1980s.⁷⁸ Favorable New Mexico precedent also emerged.⁷⁹ Most recently, a Rhode Island federal trial court predicted that the state would eventually permit bad claims against independent adjusters where the intermediary has sufficiently assumed the traditional administrative and adjusting functions of an insurer⁸⁰ and an Ohio appellate court has also written approvingly about this “management theory” of liability for parties linked to insurers when sued by persons not in direct contract privity with the defendant.⁸¹

The cases permitting actions against the adjuster tend to divide, a bit unevenly, as to both the type of action permitted and the factual

⁷⁷ See *Badillo v. Mid Century Ins. Co.*, 121 P.3d 1080, 1100-03 (Okla. 2005); *Wathor v. Mut. Assurance Adm’rs, Inc.*, 87 P.3d 559, 562-63 (Okla. 2004); *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217, 223 (Okla. Civ. App. 2002).

⁷⁸ See *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d 462, 466 (Colo. 2003) (overruling prior contrary line of cases, including *Gorab v. Equity Gen. Agents, Inc.*, 661 P.2d 1196, 1198-99 (Colo. Ct. App. 1983)).

⁷⁹ See, e.g., *Dellaira v. Farmers Ins. Exch.*, 102 P.3d 111, 115 (N.M. Ct. App. 2004) (largely following Colorado Supreme Court’s analysis in *Cary v. United of Omaha*).

⁸⁰ See *Robertson Stephens, Inc. v. Chubb Corp.*, 473 F. Supp. 2d 265, 274-275 (D.R.I. 2007).

⁸¹ See *Dombrowski v. Wellpoint, Inc.*, 879 N.E.2d 225 (Ohio Ct. App. Sept. 20, 2007). In *Dombrowski*, however, the issue for decision was slightly different in that it focused on whether a parent company of an insurer could be held responsible for insurer misconduct. *Id.* at 228-29. The federal court ruled that corporate separateness was not a bar to liability if the facts demonstrated sufficient parental company control over the insurer’s coverage and claims decisions. See *id.* at 230. Although *Dombrowski* was in a narrow sense a “piercing the corporate veil” case, the court gave a rather ringing endorsement to what it termed the “management theory” of liability for parties not in contract privity with a plaintiff and cited approvingly *Dellaira v. Farmers Ins. Exchange*, 102 P.3d 111 (N.M. Ct. App. 2004), *Delos v. Farmers Ins. Group, Inc.*, 155 Cal. Rptr. 843 (Cal. Ct. App. 1979) and other cases supporting liability for claims intermediaries that in effect take over the insurer’s traditional claims handling and decision-making function. *Id.* at 235-39.

predicate required to impose liability on the claims intermediary. One group of cases is willing to permit bad faith or similar actions against the intermediary if it is in a collaborative “joint venture” arrangement with the insurer or otherwise has stepped into the shoes of the insurer for purposes of claims administration.⁸² Another group permits claims against the adjuster based on a lower threshold of mere tort duties owed to the policyholder or other third party sufficient to permit a claim sounding in simple negligence.⁸³ Some jurisdictions appear to recognize both grounds for liability.⁸⁴ One court predicting state law was willing to allow a bad

⁸² See, e.g., *Albert H. Wohlers & Co. v. Bartgis*, 969 P.2d 949, 959 (Nev. 1998) (bad faith claim against intermediary permitted if it is in a “joint venture” with insurer as evidenced by sharing of financial incentives); *Farr v. Transamerica Occidental Life Ins. Co.*, 699 P.2d 376, 386 (Ariz. Ct. App. 1984) (same); *Dellaira v. Farmers Ins. Exch.*, 102 P.3d 111, 115 (N.M. Ct. App. 2004). See also *id.* at 116 (“An insured’s expectations of good faith handling and ultimate determination of his or her claim for benefits by the insurer extends no less to an entity that both handles and determines the claim than to the insurer issuing the policy. Absent the prospect of damages for bad faith breach, [the entity performing claims determination] has no incentive to pay in good faith[.]”) (quoting *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d 462, 468-69 (Colo. 2003)).

⁸³ See, e.g., *Bass v. Cal. Life Ins. Co.*, 581 So.2d 1087, 1090 (Miss. 1991) (intermediary can be liable for gross negligence, recklessness, or other misconduct exceeding mere negligence); *Morvay v. Hanover Ins. Cos.*, 506 A.2d 333, 335 (N.H. 1986) (adjuster owes duty of reasonable care to policyholder and may be liable for negligence); *Continental Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 287-88 (Alaska 1980) (same). See also *Shephard v. Allstate Ins. Co.*, 2006 U.S. Dist. LEXIS 562, at *18 (S.D. Ohio. June 6, 2006) (predicting that Ohio will eventually adopt this view).

⁸⁴ For example, a leading Colorado case, *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d 462, 468-69 (Colo. 2003), found defendant third-party administrator to have performed most of the functions normally done by insurer and to have a substantial financial interest in denying claims because of the administrator’s reinsurance contract with policyholder municipality. Therefore, it was logical to hold the TPA to insurer standards of conduct and liability. See also *Robertson Stephens, Inc. v. Chubb Corp.*, 473 F. Supp. 2d 265, 273-74 (D. R.I. 2007) (reading *Cary* as a case requiring substantial intertwinement of administrator and insurer similar to joint venture theory of *Wohlers* and *Farr* (See *supra* note 70) to impose bad faith liability on TPA. I read *Cary* more broadly as also permitting negligence and other tort actions against a TPA under apt circumstances even if the

TPA does not rise to the level of being a surrogate insurer subject to bad faith liability.

Oklahoma is clearly a jurisdiction that operates on a two-track system of liability for claims intermediaries. Two state supreme court cases have largely adopted the “joint venture” or “intertwinement of functions” theory of intermediary liability under which the claims intermediary may be sued for bad faith in the manner of an insurer if the facts demonstrate that the intermediary has largely assumed the functions of the insurer regarding policy administration, including wide discretion in claims decision-making, particularly if there are significant financial incentives for the intermediary to deny claims. *See* *Badillo v. Mid Century Ins. Co.*, 121 P.3d 1080, 1101-03 (Okla. 2005) (refusing to dismiss bad faith claim against intermediary at pretrial stage); *Wathor v. Mutual Assur. Adm’rs, Inc.*, 87 P.3d 559 (Okla. 2004) (accepting joint venture theory of intermediary bad faith but dismissing instant claim as a factually insufficient as a matter of law). *But see* 87 P.3d at 564 (Opala, V.C.J. and Watt, C.J., dissenting on ground that preliminary facts entitled plaintiff to discovery on intertwinement issues and that general agency principles could support tort liability depending on facts adduced at trial).

In addition, Oklahoma has a strong precedent supporting the existence of a negligence cause of action against insurance intermediaries where the facts of the case establish sufficient connection to the plaintiff to create a duty of reasonable care. *See infra* text accompanying notes 151-52 (discussing the reasoning of *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217 (Okla. Civ. App. 2002) approvingly). The state Supreme Court has never cited *Brown*, a particularly odd omission in cases like *Badillo* and *Wathor*, which dealt with the issue of intermediary liability. My own theory is that the blinders counsel and courts occasionally put on themselves created a situation in which the Supreme Court was so focused on the bad faith claims as prosecuted by the plaintiffs in *Badillo* and *Wathor* that it did not think to address whether tort liability via negligence and the *Brown* precedent might be applicable.

In any event, although *Brown* has not had ringing endorsement from the state supreme court, it continues to be treated as authoritative Oklahoma law, both for its pronouncements on tortious interference with contract and its views on claims adjuster liability, the more germane part of the opinion for purposes of this article. *See, e.g.,* *D & D Equip. & Supply Co. v. Certain Underwriters at Lloyd’s London*, 2007 U.S. Dist. LEXIS 74784, at *7-8 (W.D. Okla. Oct. 5, 2007); *Ishamel v. Andrew*, 137 P.3d 1271, 1274-75 (Okla. Civ. App. 2006). *Brown* also was favorably cited by a federal trial court applying Ohio law in an intermediary liability situation. *See* *Shephard v. Allstate Ins. Co.*, *supra* note 76, at *17. At this juncture, it thus appears that persons aggrieved by claims intermediaries may pursue either a straight-forward negligence tort for recovery or seek to sue the intermediary for bad faith where the adjuster has sufficiently assumed core insurer operations.

faith claim against an administrator sufficiently intertwined with an insurer but refused to allow a simple negligence action against the administrator.⁸⁵ As discussed in more detail below, my proposed framework for intermediary liability would permit both types of actions against adjusters based on the facts of the particular case.⁸⁶

Despite their differences at the margin, the common thread of these decisions is not so much a rejection of the general rule as a recognition that in many cases, insurance intermediaries act more like substitute insurers than mere agents. Almost all of the decisions sustaining liability claims insisted that the intermediary engage in more than merely ministerial and robotic claims handling commanded by the insurer as principal to the intermediary's limited agency.⁸⁷ Some of these decisions went further in

⁸⁵ See, e.g., *Robertson Stephens*, 473 F. Supp. 2d, at 273-78. The *Robertson Stephens* opinion is so thorough and scholarly that one flinches from disagreeing with it, even in part. However, the Court's refusal to permit a negligence action in a situation it found apt for a bad faith action seems irreconcilably inconsistent, even if it as a practical matter does not strip the plaintiff of any serious litigation prerogatives. (If the policyholder can sue for bad faith, suing for mere negligence is unlikely to lead to a greater recovery.) If the claims administrator is sufficiently linked to the insurer to be sued as an insurer and owe a fiduciary-like duty of good faith to the policyholder, this same administrator must also logically owe the policyholder at least a basic tort duty of reasonable care.

Robertson Stephens is a finely crafted opinion that seems to veer off track in this regard, although it was arguably forced to by controlling Rhode Island precedent, particularly the state's general hesitance to impose on commercial actors liability for negligence toward third parties. See *id.* at 276-81. The Court noted that it was "not entirely unsympathetic to Plaintiffs' call to augment in law the obligations of independent administrators . . . but Rhode Island precedents and the majority approach [of adjuster immunity absent a joint venture with the insurer] must stay the Court's hand. The Rhode Island Supreme Court is perfectly capable of pioneering new frontiers in the law of negligence on its own, and is in a better position to do so." See *id.* at 280-81 (also noting that plaintiff chose federal forum and therefore cannot "grumble" about federal court reluctance to push boundaries of state law).

⁸⁶ See *infra* text accompanying notes 177-221.

⁸⁷ *Bayless & Roberts* and *Morvay* are arguably close to permitting liability even if the agency is limited. See *supra* notes accompanying text 49-63. For example, the *Robertson Stephens* court read them this way. See *Robertson Stevens*, 473 F Supp. 2d at 280. I disagree. In both *Bayless* and *Morvay*, the agents (an

requiring substantially autonomous claims administration so that the intermediary was in effect the decisionmaker regarding the claim and not merely a vessel of communication between insurer and policyholder.⁸⁸ Some also required a partnership or joint venture-like financial stake by the intermediary that gave it an incentive to dispute claims going beyond whatever natural tendency the adjuster might have to minimize payments in order to please the principle.⁸⁹

As the Oklahoma Supreme Court observed:

In a situation where a plan administrator performs many of the tasks of an insurance company, has a compensation package that is contingent on the approval or denial of claims, and bears some of the financial risk of loss for the claims, the administrator has a duty of good faith and fair dealing to the insured.⁹⁰

If an intermediary “acted sufficiently like an insurer” to create a “special relationship” between policyholder and intermediary, the intermediary could be liable to the same extent as an insurer.⁹¹

Nevada took a similar view but couched it in perhaps problematic language requiring that the degree of the intermediaries assumption of insurer functions rise to the level of a “joint venture.” The general rule of insurer immunity remained operative but where an intermediary was engaged in a “joint venture” with the insurer, the intermediary was subject

investigator and an adjuster) had substantial autonomy in conducting their duties and substantial practical control over the outcome of the claims in question.

⁸⁸ Oklahoma’s *Badillo* and *Wathor* cases fall into this category, as arguably does *Cary v. United of Omaha*. See *supra* notes accompanying text 78, 82-4.

⁸⁹ The joint venture cases, *Wohlers* and *Farr*, clearly are in this vein. Also, one might argue that *Badillo*, *Wathor*, and *Cary* also depended on some significant financial incentive impinging on the claims adjuster’s ability to be fair.

⁹⁰ See *Wathor*, 87 P.3d at 563.

⁹¹ See *id.* at 563. However, on the facts of that particular case, the Court found that the intermediary did not “act sufficiently like an insurer.” *Id.* at 562.

to the duties of an insurer and faced potential liability similar to that of an insurer.⁹² According to the Nevada Supreme Court, the instant case provided sufficient evidence of the requisite joint venture in that the intermediary

[d]eveloped promotional material, issued policies, billed and collected premiums, adjudicated claims, and assisted [the insurer] in the development of [contract language]. Further, because [the intermediary] shared in [the insurer's] profits, it had a direct pecuniary interest in optimizing [the insurer's] financial condition by keeping claims costs down. [The intermediary's] administrative responsibilities and its special relationship with [the insurer are] indicative of the existence of a joint venture. . . .

Due to the extent of [the intermediary's] administrative responsibilities, policy management duties, and special relationship . . . we conclude that [the intermediary and the insurer] were involved in a joint venture to an extent sufficient to expose [the intermediary] to liability on all contract-based and bad faith claims.⁹³

Although the Nevada decision arguably would have been more doctrinally satisfying if it had simply said that MGAs or other intermediaries taking on insurer roles were subject to the law governing

⁹² In *Wohlers*, the court noted:

In general, no one "is liable upon a contract except those who are parties to it." *County of Clark v. Bonanza No. 1*, 96 Nev. 643, 548-49, 615 P.2d 939, 943 (1980). However, according to a well-established exception to this general rule, where a claims administrator is engaged in a joint venture with an insurer, the administrator "may be held liable for its bad faith in handling the insured's claim, even though the organization is not technically a party to the insurance policy." William M. Shernoff et al., *Insurance Bad Faith Litigation* § 2.03[1], at 2-10 (1998).

Wohlers, 969 P.2d at 959 (citing *County of Clark* and William M. Shernoff).

⁹³ *See id.* at 959.

insurers (and dispensing with joint venture talk),⁹⁴ it was not only another state supreme court supportive of a departure from inflexible application of the historical rule but also provided a striking illustration of the degree to which MGAs in fact often take over insurer functions. The MGA found liable in Nevada’s *Wohlers* decision was a world away from the traditional limited autonomy agents the law envisioned when it adopted the historical rule of intermediary immunity when the agent’s principal was disclosed.⁹⁵

⁹⁴ The very terminology “joint venture,” tends to conjure up images of major, formal business combinations and thus subconsciously suggests that much is required before MGA or claims intermediary can be held liable like an insurer. However, all that is really necessary is relatively standard administrator or adjuster behavior. When the joint venture language is peeled back, the Nevada Supreme Court appears to be saying that where an intermediary acting within its authority makes a key coverage decision in place of the insurer, the intermediary should be liable like an insurer, particularly if the intermediary has economic incentives adverse to coverage and is involved in significant administrative operations for the insurer.

In adopting the joint venture terminology and concept, the Nevada Supreme Court was obviously influenced by the treatise it cited authored by prominent California policyholders’ attorney William Shernoff. Shernoff characterized pre-*Wohlers* case law as supporting MGA and adjuster liability if they were sufficiently intertwined with the insurer to constitute a joint venture. Although this is one valid interpretation, one could as easily look at the case law assessed by Shernoff and concluded that the pre-*Wohlers* courts were looking not so much for a joint venture as for situations in which the intermediary was making decisions historically made by the insurer rather than one of its agents.

⁹⁵ Nevada is not alone in its attraction to the joint venture rationale as well as the realization that much of modern insurance is administered not by the insurer itself but by intermediaries. *Farr v. Transamerica Occidental Life Ins. Co. of Cal.* took a similar approach and found, much like *Wohlers*, that a health insurer’s independent claims adjuster was sufficiently economically linked to the insurer to be liable to the policyholder on a joint venture theory. *Farr*, 699 P.2d at 386.

Farr’s imposition of liability upon an intermediary creates some tension in Arizona law because another prominent Arizona case is frequently cited in support of modern adherence to the traditional rule of adjuster immunity. See *Meineke v. GAB Business Services, Inc.*, 991 P.2d 267, 271 (Ariz. Ct. App. 1999) (basing independent adjuster immunity on grounds of lack of contract privity). See also *Napier v. Bertram*, 954 P.2d 1389, 1394-1395 (Ariz. 1998) (independent insurance agent had no duty to taxicab passenger to ensure that taxicab company has required uninsured motorist coverage; Court feared that imposition of liability would “impose on agents a duty to a vast number of non-clients—literally all who reside in or travel in this state”).

In *Cary v. United of Omaha Life Insurance*,⁹⁶ Colorado set forth one of the most recent and forceful rejections of the traditional approach. The City of Arvada provided a self-funded insurance program to its employees, one managed by United of Omaha and Mutual of Omaha of Colorado (the Plan Administrators). Thomas Cary's 15-year-old daughter shot herself while attempting suicide, incurring substantial injuries that required extensive medical treatment, including multiple surgeries and hospitalization. The Plan Administrators denied Cary's claim for benefits based on an exclusion in the policy for self-inflicted injuries. He responded by suing for benefits and seeking damages for bad faith against the Plan Administrators.

The trial court agreed with claimant Cary that the self-inflicted injuries provision of the policy was ambiguous and ruled in favor of coverage but held that the Plan Administrators could not be sued for bad faith because "Cary was not in contractual privity with the Administrators." The Colorado Court of Appeals affirmed on similar grounds. The Colorado Supreme Court reversed, stating that it disagreed with the court of appeals' strict application of a privity of contract analysis to this case. Here, the insurance administrators had primary control over benefit determinations, assumed some of the insurance risk of loss, undertook many of the obligations and risks of an insurer, and had the power, motive, and opportunity to act unscrupulously in the investigation and servicing of the insurance claims. Under such circumstances, we hold that a special relationship existed between the Administrators and the insured sufficient to establish in the Administrators a duty to act in good faith.⁹⁷

The cases are reconcilable in that *Meineke* based its holding on a view that in the instant case the "relationship between adjuster and insured is sufficiently attenuated by the insurer's control over the adjuster to be an important factor that militates against imposing a further duty on the adjuster to the insured." *Meineke*, 991 P.2d at 270. Neither *Meineke* nor *Napier* cited *Farr* but *Farr* remains good law in Arizona. Presumably, then, an Arizona court faced with adjuster-insurer intertwinement sufficient to make for a "joint venture" would, like the Nevada Supreme Court in *Wohlbers*, refuse to immunize the intermediary.

⁹⁶ 68 P.3d 462 (Colo. 2003).

⁹⁷ *Id.* at 465. Under Colorado bad faith law, in order to prevail, Cary would be required to prove that the Plan Administrators had acted unreasonably and either "knew their conduct was unreasonable or acted in reckless disregard of whether their conduct was unreasonable." *Id.*

In addition to the these facts of Plan Administrator authority and conduct that supported permitting the claim, the Court also made a legal analysis differentiating cases of this type from those subject to the general rule of immunity from suit in the absence of privity. First, it noted that “insurance contracts are not ordinary commercial contracts” and that breach of the insurer’s duty of good faith gives rise to a tort action.⁹⁸

In the typical insurance case, only the insurer owes the duty of good faith to its insured; agents of the insurance company – even agents involved in claims processing – do not owe a duty, since they do not have the requisite special relationship with the insured.

* * *

In the typical case, the insured is adequately protected by the non-delegable duty the law imposes on the insurer. However, the existence of this nondelegable duty does not mean that a third-party claims administrator never has an independent duty to investigate and process the insured’s claim in good faith. When the actions of a defendant are similar enough to those typically performed by an insurance company in claim administration and disposition, we have found the existence of a special relationship sufficient for imposition of a duty of good faith and tort liability for its breach – even when there is no contractual privity between the defendant and the plaintiff.⁹⁹

⁹⁸ Colorado had not formally recognized first-party insurance bad faith actions until the mid-1980s. See *Farmers Group, Inc., v. Trimble*, 691 P.2d 1138, 1141 (Colo. 1984).

⁹⁹ See *Carey*, 68 P.3d at 466-67. As the Court noted, prior case law had already eroded the wall of immunity provided under the traditional rule. For example, in *Travelers Ins. Co. v. Savio*, the Court held that a workers compensation insurer owes a duty of good faith to the employees within the scope of the plan and not only to the employer who purchased the policy. 706 P.2d 1258, 1264-65 (Colo. 1985). In *Transamerica Premier Ins. Co. v. Brighton Sch. Dist.*, the Court ruled that sureties were subject to the bad faith regime that governed insurers. 27J, 940 P.2d 348, 352 (Colo. 1997). In addition, the Court had moved

Consequently, “[w]hen a third-party administrator performs many of the tasks of an insurance company and bears some of the financial risk of loss for the claim, the administrator has a duty of good faith and fair dealing to the insured in the investigation and servicing of the insurance claim.”¹⁰⁰

Two justices dissented, viewing the majority’s expansion of potential liability to additional insurance activity participants as “unworkable” even if its social policy goal of protecting insureds “by providing a disincentive for wrongful behavior by agents of the insurer” as well as “an alternative source of recovery” was “laudable.”¹⁰¹ Invoking policy considerations of its own, the Dissent also argued that bad faith exposure for the Plan Administrator was inappropriate because it was obligated to serve the interests of the City of Arvada, which might often be in conflict with the interests of employees like Cary. Whatever empathy it felt for the family, the City might have preferred the claim be denied in order to have more coverage available for other matters or to keep payment for the program to a minimum.¹⁰²

Even in California, often cited as the home of continuing adherence to the general rule that claims intermediaries as mere agents are not subject to suit, there is appellate court caselaw permitting such claims where the

away from strict privity requirements in other contexts. *See, e.g.*, *Cosmopolitan Homes v. Weller*, 663 P.2d 1041, 1042-43 (Colo. 1983) (homebuilder owed duty of care to subsequent purchaser even if no contract privity between builder and purchaser).

¹⁰⁰ *See Carey*, 68 P.3d at 469.

¹⁰¹ *Id.* at 469 (Coats, J., dissenting, joined by Kourlis, J.).

¹⁰² In *Carey*, the court noted that:

[T]he significance of [the Administrator’s] involvement in processing claims for the City is not that it is acting *like* an insurer but rather that it is acting *for* an insurer. To the extent that it insured the City with a stop-loss or reinsurance policy, it has a “semi-fiduciary” relationship with the City, its insured, and owes the City a special duty that potentially conflicts with a similar duty to the City’s insured.

Id. at 471 (emphasis in original).

intermediary has taken on the essential identity of an insurer or is intertwined economically with the insurer beyond a mere independent contracting relationship.¹⁰³ There is also some authority finding rights as intended third party beneficiaries for persons that are not part of the contract between policyholder and insurer,¹⁰⁴ although there is also much precedent taking a narrower view of entitlement to contract benefits.¹⁰⁵

¹⁰³ See, e.g., *Bus. to Bus. Mkts, Inc. v. Zurich Specialties London Ltd.*, 37 Cal. Rptr. 3d 295, 299, 300 (Cal. Ct. App. 2005) (surplus lines broker may owe duty to judgment creditor plaintiff for negligence in procuring insurance policy for judgment debtor policyholder that did not cover work done by policyholder in India); *Tran v. Farmers Group, Inc.*, 128 Cal. Rptr. 2d 728, 740-41 (Ct. App. 2003); *Delos v. Farmers Group, Inc.*, 155 Cal. Rptr. 843, 849 (Cal. Ct. App. 1979) (“for legitimate business considerations, the [administrative intermediary] was formed to render management services for the [insurer] for which it received a percentage of premiums paid by the [insurer’s] policyholders”). See also *id.* at 653, 850 (administrative intermediary was “engaged in the business of insurance” and “may be held liable” under state unfair claims practices statute). *Id.*

The same is true for Arizona, which is generally considered a state favoring the traditional rule of claims adjuster immunity on the strength of *Meineke v. GAB Business Services, Inc.*, 991 P.2d 267, 268 (Ariz. Ct. App. 1999), at least where the adjuster’s agency authority is relatively circumscribed. But where the claim intermediary has substantial authority or more than a mere contract to perform ministerial services, Arizona courts have either permitted claims against the intermediary by policyholders or suggested that liability may be apt. See, e.g., *Gatecliff v. Great Republic Life Ins.*, 821 P.2d 725, 731 (Ariz. 1991) (recognizing management theory as basis for holding insurer responsible for TPA misconduct); *Farr v. Transamerica Occidental Life Ins. Co. of Cal.*, 699 P.2d 376, 386 (Ariz. Ct. App. 1984) (TPA may be liable to policyholder when there is sufficient economic intertwining with insurer to constitute joint venture-like linkage between them). Accord, *Sparks v. Republic Nat’l Life Ins. Co.*, 647 P.2d 1127, 1137-38 (Ariz. 1982) (approving jury instruction on joint and several liability regarding claims intermediary handling investigation and payment of claims, determining joint venturers both owed common duty of good faith toward policyholders).

¹⁰⁴ See, e.g., *Delos*, 155 Cal. Rptr. at 853. (“There are no public policy or doctrinal considerations that preclude Mr. Delos from having an independent cause of action against defendants. He was a party to the insurance contract and the effect upon him of the improper denial of his wife’s claim was reasonably foreseeable”).

¹⁰⁵ See, e.g., *Jones v. Aetna Cas. & Sur. Co.*, 33 Cal. Rptr. 2d 291, 294-95 (Cal. Ct. App. 1994) (tenant not intended third-party beneficiary to insurance

Although the state's Supreme Court has never endorsed any of these approaches, neither has it disapproved them in the context of claims intermediaries.

In addition, the "alter ego of the insurer" and "joint venture" theories are arguably perfectly consistent with famous California precedent rejecting claims against intermediaries (*Gruenberg, Egan, Iversen*)¹⁰⁶ in that in all of these cases, the Supreme Court considered the intermediaries to be engaged only in more limited, ministerial agency rather than a joint venture with the insurer or assumption of the insurer's role. Further, the immunity for insurance intermediaries, at least if they have substantial authority, would also appear to be inconsistent with state law permitting professionals such as an auditor or notary public to be held liable to persons that are not strictly part of the contract in question.¹⁰⁷

Going into the 21st Century, one might have reasonably predicted increasing erosion of the traditional rule of claims intermediary immunity from suit by policyholders or other claimants allegedly injured by the intermediary's errors or misconduct. However, the formal doctrines shielding these intermediaries have proven surprisingly resilient.

C. THE PUZZLING PERSISTENCE OF THE TRADITIONAL RULE

Notwithstanding the emergence of a significant number of cases holding that intermediaries sufficiently assuming insurer functions could be liable to the same extent as insurers, many courts continue to apply the traditional doctrine and to accord broad immunity to MGAs and

policy contract between lessor/policyholder and insurer). *See also id.* at 1724, 295 ("it is well settled that [California law] excludes enforcement of a contract by persons who are only incidentally or remotely benefited by it") (citing Cal. Civil Code § 1559 and *Lucas v. Hamm*, 364 P.2d 685 (Cal. 1961)).

¹⁰⁶ *See Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 154 (Cal. 1979); *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1038 (Cal. 1973); *Iversen v. Superior Court*, 57 Cal. App. 3d 168, 170 (Cal Ct. App. 1976).

¹⁰⁷ *See Biakanja v. Irving*, 320 P.2d 16, 17-19 (Cal. 1958) (notary public can be liable to persons reasonably expected to rely on notarization even if these persons were not in contractual privity with notary and person contracting to have signature notarized).

independent adjusters.¹⁰⁸ Courts continue to hold that a claimant does not have standing to bring a claim directly against an independent adjuster or administrator.¹⁰⁹

¹⁰⁸ See, e.g., *Wolverton v. Bullock*, 35 F. Supp. 2d 1278, 1280-81 (D. Kan. 1998)(Kansas law does not permit policyholder to bring bad faith action against independent adjuster due to lack of contract privity); *Natividad v. Alexsis, Inc.*, 875 S.W.2d 695, 698-9 (Tex. 1994)(policyholder may not sue independent adjuster for alleged bad faith in administering claim); *Koch v. Bell, Lewis & Assoc., Inc.*, 627 S.E.2d 636, 638-39 (2006); *Meineke v. GAB Bus. Servs., Inc.*, 991 P.2d 267, 270-71 (Ariz. Ct. App. 1999); *King v. Nat'l Sec. Fire and Cas. Co.*, 656 So.2d 1338, 1339 (Fla. Dist. Ct. App. 1995); *Larkin v. First of Georgia Underwriters*, 466 So.2d 655, 657 (La. Ct. App. 1985) (insurance MGA not subject to bad faith claim by policyholder due to lack of contract privity); *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 154 (Cal. 1979)(independent agents selling and servicing policies for disclosed insurer not subject to covenant of good faith and fair dealing with policyholder due to absence of contract privity); *Troxel v. American States Ins. Co.*, 596 N.E.2d 921, 925 (Ind. Ct. App. 1992); *Bentley v. N.C. Ins. Ass'n*, 418 S.E.2d 705, 707 (N.C. Ct. App. 1992); *Amica Mut. Ins. Co. v. Schettler*, 768 P.2d 950 (Utah Ct. App. 1989). *Accord* *Kim v. O'Sullivan*, 137 P.3d 61, 62, 65 (Wash. Ct. App. 2006)(no policyholder cause of action against insurer-provided attorney for legal malpractice because of lack of express contract between attorney and policyholder); *Scribner v. AIU Ins. Co.*, 647 A.2d 48, 51 (Conn. Super Ct. 1994)(no claim against attorney for insurer due to lack of contract privity). See also *Badners v. Prudential Life Ins. Co. of America*, 567 So. 2d 1242, 1244 (Ala. 1990)(no policyholder claim against bank that was supposed to debit monthly premium payments for life insurer due to lack of contract privity between bank and policyholder's ex-spouse, who suffered injury due to missed payments and lapsed policy prior to policyholder's death).

Kim v. O'Sullivan clearly seems wrongly decided. Although many states consider insurers to be “clients” of an attorney retained by the insurer to defend third party's lawsuit against a policyholder, all states consider the policyholder to be the lawyer's client by operation of law even in the absence of a written retainer agreement between counsel and the policyholder. Consequently, it simply cannot be correct that the policyholder has no claim for legal malpractice against a malfunctioning defense lawyer retained by its insurer. Some states even provide that only the policyholder is a client of the attorney and that insurers are but third party payers with contract rights vis-à-vis counsel.

¹⁰⁹ See, e.g., *Charleston Dry Cleaners & Laundry v. Zurich Am. Ins. Co.*, 586 S.E.2d 586, 588-89 (S.C. 2003); *Meineke*, 991 P.2d at 270; *Sanchez v. Lindsey Morden Claims Servs., Inc.*, 72 Cal. Rptr. 2d 799, 802 (1999); *King v. Nat'l Sec.*

In some instances, legal arguments for removing intermediary immunity probably fall on deaf judicial ears because the facts of the case are not particularly compelling for the plaintiff. For example, in *Akpan v. Farmers Ins. Exchange, Inc.*,¹¹⁰ the policyholders, owners of a convenience store, suffered three separate incidents of burglary and vandalism within a two-week period. Although this alone does not make the claim suspicious, the policyholders' post-loss behavior undoubtedly raised eyebrows as they backed out of submitting to an examination under oath on five separate occasions, ultimately refusing to answer questions about the losses. When they sued the insurer and independent adjuster, the court was not very sympathetic in view of the case's aroma of insurance fraud.¹¹¹

Further, the policyholder claim against the intermediary was that it had been slow to deliver a copy of the policy to the claimants. Because the duty to cooperate and submit to examination if requested is so common in first-party property insurance, it is hard to take seriously the contention that without a copy of the policy, the insured was unsure of its basic obligations in this regard. Even if the delay in furnishing a copy of the policy was wrongful and unreasonable, *Akpan* hardly presented an attractive case for

Fire and Cas. Co., 656 So.2d 1338 (Fla. Dist. Ct. App. 1995); *Velastequi v. Exch. Ins. Co.*, 132 Misc.2d 896, 897 (N.Y. Civ. Ct. 1986).

As previously discussed, the judicial immunity for adjusters facing lawsuits from claimants is hardly surprising in light of the general rule that third party claimants may not sue insurers (other than their own) directly because of the law of privity. *See* notes 8-12, *supra*. If there has been bad faith by the insurer, the claim is often pursued by the claimant possessing an assignment of rights from the policyholder. In some states, bad faith claims are considered personal and non-assignable. In these states, a policyholder may agree to sue its insurer for bad faith and to award most of any proceeds from the suit to the third-party claimant as a means of settling the underlying tort litigation between the claimant and the policyholder.

¹¹⁰ *Akpan v. Farmers Ins. Exch., Inc.* 961 So.2d 865, 866 (Ala. Civ. App. 2007).

¹¹¹ *Id.* at 867-71 (emphasizing importance of policyholder's compliance with policy provision requiring it to submit to examination under oath if requested by insurer).

departing from the traditional rule and permitting suit against the independent adjuster.¹¹²

*Dear v. Scottsdale Insurance Co.*¹¹³ presented similar problems for the cause of law reform. Policyholder Dear was a private investigator with professional liability coverage. He was sued by a former client for alleged overcharging and “fraudulent and negligent” investigation. During mediation, the former client made a policy limits (\$300,000) demand to resolve the case, one which the mediator had advised the insurer that it would be “well advised to accept [plaintiff’s] policy limits demand” and that the mediator “believed that a jury might find against Dear” and award significant damages.”¹¹⁴ Not surprisingly, the insurer settled, as was its right under the terms of the liability policy. In a subsequent smaller case, Dear was sued by the former client’s mother for an allegedly intrusive investigation in retaliation and then was sued by two other clients for “improprieties while investigating their daughter’s disappearance.”¹¹⁵ The insurer settled both of these claims as well.

Demonstrating that good deeds rarely go unpunished, Dear sued the insurer, the adjuster, the insurance sales agent, and the law firm that defended the claims. His claim against the adjuster is that it changed its evaluation of the case in response to “pressure” from the defense attorney, conducted a poor investigation, settled a claim in spite of his objection, and tortiously interfered with his relationship with the insurer. Reading the case, one gets the impression that the policyholder was in essence suing the parties for saving him from himself. Clearly, he faced substantial claims

¹¹² Nonetheless, the *Apkan* Court felt compelled to cite nearly all the modern cases on the subject, noted the majority approach, embraced the reasoning of majority rule cases, and rejected the analysis of cases like *Bayless and Roberts* and *Morvay*. See *Apkan*, 961 So. 2d at 873-74. See *infra* text accompanying notes 49-71 for criticism of the analyses of modern traditional rule cases such as *Sanchez v. Lindsey Morden Claims Servs., Inc.*, 84 Cal. Rptr. 2d 799 (1999) and *Meineke v. GAB Bus. Servs.*, 991 P.2d at 267, both of which have been influential in shoring up traditional intermediary immunity in the faces of cases like *Morvay* and *Bayless and Roberts*.

¹¹³ *Dear v. Scottsdale Ins. Co.*, 947 S.W.2d 908 (Tex. App. 1997).

¹¹⁴ *Id.* at 911.

¹¹⁵ *Id.* at 911-12.

that could have resulted in an excess verdict and his own personal exposure had settlement not been effected. The claim of settlement without confidentiality, however, is more compelling in view of the bad publicity that dissemination of the lawsuit information could produce for someone in Dear's line of work.

Nonetheless, the case as a whole is not one that would likely prompt a court to make new law to assist a sympathetic claimant. The *Dear* result – continued adherence to the rule of intermediary immunity, was also aided not only by a relatively recent state supreme court decision affirming adjuster immunity¹¹⁶ but also by substantive Texas law which does not impose on insurers a specific common law duty of good faith in the investigation and defense of claims, although it requires insurers to accept reasonable settlement offers within available policy limits.¹¹⁷

But even where the policyholder's plight is sympathetic, a number of modern cases continue to cleave strongly to the traditional rule. In *Troxell v. American States Insurance Co.*, the policyholders suffered a home fire.¹¹⁸ The insurer hired an independent investigator to perform a cause and origin analysis of the fire, which resulted in an adverse

¹¹⁶ See *id.* at 916 (citing *Natividad v. Alexsis, Inc.*, 875 S.W.2d 695, 698 (Tex. 1994)).

¹¹⁷ See *id.* at 914, (citing *Maryland Ins. Co. v. Head Indus. Coatings & Servs., Inc.*, 938 S.W.2d 27, 27-29 (Tex. 1996)).

The duty to settle in Texas is routinely labeled the "*Stowers* duty" but Texas common law has otherwise been resistant to imposing other good faith obligations on insurers. However, Texas policyholders enjoy significant statutory rights and remedies. See, e.g., TEX. INS. CODE ANN. § 541.151 (2005) (unfair and deceptive practices in the business of insurance); TEX. INS. CODE ANN. § 542.060 (unfair claims settlement practices); TEX. BUS. & COM. CODE ANN. § 17.41-17.826; *Warren v. State Farm Mut. Auto Ins. Co.*, No. 3:08-CV-0768-D, 2008 U.S. Dist. LEXIS 68646 (N.D. Tex. Aug. 29, 2008) (insurer defendant seeking to remove policyholder statutory claim to federal court bears heavy burden to demonstrate lack of any reasonable basis for recovery under Texas unfair claims practices statutes); *South Texas Med. Clinics, P.A. v. CNA Fin. Corp.*, No. H-06-4041, 2008 U.S. Dist. LEXIS 11460 (S.D. Tex. Feb. 15, 2008) (Chapter 542 claim requires that there be coverage under the policy at issue to permit unfair practices claim and Chapter 541 claim may be sustained on unfair claims practices independent of coverage determination).

¹¹⁸ 596 N.E.2d 921 (Ind. Ct. App. 1992).

evaluation and the policyholder being “indicted on charges of arson” with the investigator serving as a prosecution witness at trial.¹¹⁹ After the policyholder was acquitted, she sued the insurer and investigator.¹²⁰

The suspicions of arson may have been reasonable (depending on the evidence), but if they were not the investigator’s activity caused more than a little harm to the policyholder, harm that was readily foreseeable to an investigator that should at least constructively have been aware that in acting as an agent of an insurer it was required to proceed with good faith toward the policyholder.¹²¹ But the court remained unmoved by Troxell’s plight, at least as respects the immunity of intermediaries. The investigator “was the agent of [the insurer] and had no direct [contract] relationship” with the policyholder and hence was immune from suit.¹²²

If nothing else, the sheer weight of history and precedent have made it difficult for reformist decisions such as *Bayless & Roberts*,¹²³ *Morvay*,¹²⁴ or *Cary*¹²⁵ to get traction in other jurisdictions. For example, the South Carolina Supreme Court, although aware of the split in authority on the topic, viewed immunity for intermediaries as continuing to be the solidly entrenched majority rule.¹²⁶ “We decline to recognize a general duty of due care from an independent insurance adjuster or insurance adjusting company to the insured, and thereby align South Carolina with the majority rule on this issue.”¹²⁷

¹¹⁹ *Id.* at 922.

¹²⁰ *Id.*

¹²¹ *See id.* at 925.

¹²² *Id.* at 925, n.1.

¹²³ 608 P.2d 281.

¹²⁴ 506 A.2d 333.

¹²⁵ 68 P.3d 462.

¹²⁶ *See* *Charleston Dry Cleaners & Laundry, Inc. v. Zurich Am. Ins. Co.*, 586 S.E.2d 586, 588-89 (S.C. 2003).

¹²⁷ *Id.*

The Court based its continued preference for immunity on the state precedent holding that “foreseeability of injury is an insufficient basis for recognizing a duty” of good faith or reasonable care.¹²⁸ It also strongly suggested that intermediary liability was unnecessary because “a bad faith claim against the insurer remains available as a source of recovery for a [policyholder] plaintiff” [and that] “in a bad faith action against the insurer, the acts of the adjuster or adjusting company (agent) may be imputed to the insurer (principal).”¹²⁹

Despite the strong support for intermediary liability (at least when the intermediary steps significantly into the shoes of the insurer) expressed by the New Hampshire Supreme Court in *Morvay*,¹³⁰ neighboring Vermont took quite a different view some 20 years later. In *Hamill v. Pawtucket Mutual Ins. Co.*¹³¹ the Vermont Supreme Court specifically rejected *Morvay* and affirmed a trial court’s summary judgment in favor of independent insurance adjusters, finding no legal duty owed by the adjusters to the policyholders – at least for solely economic damages claimed from alleged negligent investigation and evaluation, including substantial delay in processing the claim.

In *Hamill*, the homeowner policyholder was away on a business trip during which a power outage took place, resulting in loss of heat to the home, frozen pipes, and subsequent pipe bursting and flooding.¹³² When the policyholder sought recovery under the policy, the insurer contracted with independent adjusters to handle the claim.¹³³ The policyholder provided estimates of the damage ranging from \$150,000 to \$200,000.¹³⁴

¹²⁸ See *id.* at 588 (citing *South Carolina State Ports Auth. v. Booz-Allen & Hamilton, Inc.*, 346 S.E.2d 324, 325 (S.C. 1986) (foreseeability of injury alone does not create duty owed to foreseeably injured party)).

¹²⁹ See *id.* at 589.

¹³⁰ 506 A.2d 333.

¹³¹ 892 A.2d at 228-29.

¹³² *Id.* at 227.

¹³³ *Id.*

¹³⁴ *Id.*

In response, the adjuster “rejected the estimates, accused [policyholder] Hamill of insurance fraud, and offered to settle the matter then and there for \$5,000.”¹³⁵

Even if these allegations were true, the Vermont Court was unmoved.¹³⁶ Like the South Carolina Court in *Dry Cleaners*,¹³⁷ *Hamill* found foreseeable injury alone an insufficient basis for created a duty to the policyholder.¹³⁸ Siding with and citing cases for the majority rule, the *Hamill* Court found the adjuster protected by both the absence of a contract directly with the policyholder and that imposing liability would be “contrary to the law of agency” since the adjuster worked for a disclosed principal.¹³⁹

Further, the Court found public policy considerations to weigh against imposing liability upon claims intermediaries because “in most cases, imposing tort liability on independent adjusters would create a redundancy unjustified by the inevitable costs that eventually would be passed on to insureds.”¹⁴⁰

¹³⁵ See *id.* at 227. Hamill also alleged that after he rejected the adjuster’s settlement offer, [adjuster] Andrulat did not get back to him for weeks, even though Andrulat knew or should have known that the water-damaged premises needed to be repaired immediately to prevent the possibility of mold growth. According to the complaint, [Hamill also alleged that] as a result of Andrulat’s failure to carefully investigate Hamill’s claims, to consider his repair estimates, and to make an immediate and thorough inspection of the subject premises, mold spread through the house, making it uninhabitable. [Had the adjustment process been conducted properly]...the interior of Hamill’s house would have been gutted and rebuilt before the mold had begun to grow. *Id.*

¹³⁶ *Hamill*, 892 A.2d 226.

¹³⁷ 586 S.E.2d 586.

¹³⁸ 892 A.2d at 227-28.

¹³⁹ *Id.*

¹⁴⁰ See *id.* at 230-31 (noting that policyholder Hamill had settled bad faith and breach of contract claims against his insurer and that he had not produced any evidence that he had not been sufficiently compensated by that settlement).

In addition, “the insurer contractually controls the responsibilities of its adjuster and retains the ultimate power to deny coverage or pay a claim.”¹⁴¹ Another consideration was that

to some extent, insurers can define and limit their risks, and set their premiums commensurate with those risks through conditions, limits, and exclusions in their insurance policies. . . . In contrast, absent any contract with insured, adjusters cannot circumscribe their potential risks and thus could face potentially open-ended liability. This is particularly troublesome because of the unlikelihood that an action claiming negligent mishandling of a claim would be available against even the insurer.¹⁴²

The *Hamill* Court also rejected the argument that Vermont’s unfair claims practices act or other insurance regulator statutes applied to independent claims adjusters.¹⁴³

III. THE BENEFITS OF ACCOUNTABILITY: ILLUSTRATIONS OF THE POTENTIAL MISCHIEF OF INTERMEDIARY IMMUNITY

In spite of its tenacious persistence and resistance to cases like *Bayless*¹⁴⁴ and *Morvay*,¹⁴⁵ the traditional approach of intermediary immunity has become inappropriate to the modern world of insurance. Although cases like *Hamill*¹⁴⁶ in Vermont and *Charleston Dry Cleaners*¹⁴⁷

¹⁴¹ See *id.* at 231.

¹⁴² See *id.* (citing *Sanchez v. Lindsey Morden Claims Servs., Inc.*, 84 Cal. Rptr. 2d 799, 801-03 (Cal. Ct. App. 1999) and *Meineke v. GAB Business Servs., Inc.*, 991 P.2d 267, 271 (Ariz. Ct. App. 1999)).

¹⁴³ See 892 A.2d at 231-32.

¹⁴⁴ 608 P.2d 281.

¹⁴⁵ 506 A.2d 333.

¹⁴⁶ 829 A.2d at 230.

¹⁴⁷ 586 S.E.2d 586.

in South Carolina make substantial public policy arguments in favor of intermediary immunity, they are ultimately no more persuasive than the dated formalism of the citadel of privity or rigid adherence to the disclosed principal rule of agency law. These modern cases, like their predecessors, rest on a weak foundation of questionable empiricism and argument.

Examining a leading case favoring intermediary immunity serves to illustrate the comparative weakness of arguments for intermediary immunity. *Sanchez v. Lindsey Morden Claims Services, Inc.*,¹⁴⁸ is a case frequently cited in support of continued adherence to the traditional rule of intermediary immunity and is unusual in that, like the Vermont Supreme Court's *Hamill*¹⁴⁹ opinion (which built on *Sanchez*), it defends the traditional rule upon functional public policy grounds rather than merely invoking the formalism of disclosed agency and lack of contract privity, although those were also applied by the *Sanchez* Court.

In contrast to *Sanchez*,¹⁵⁰ *Brown v. State Farm Fire & Casualty Co.*,¹⁵¹ like the Colorado Supreme Court's *Cary* opinion discussed above, rejects the traditional rule of intermediary immunity on the basis of extensive functional analysis rather than any outright refusal to follow traditionally venerable privity and agency doctrine.¹⁵² Upon closer examination, the *Sanchez*¹⁵³ public policy reasons for the traditional rule wilt while the analysis of *Brown*¹⁵⁴ and *Cary*¹⁵⁵ (like *Morvay* and *Bayless & Roberts*) is more persuasive. However, because *Sanchez* and its deceptive policy-based assessment has been influential in shoring up the traditional

¹⁴⁸ 84 Cal. Rptr. 2d 799.

¹⁴⁹ 829 A.2d 226.

¹⁵⁰ 84 Cal. Rptr. 2d 799.

¹⁵¹ 58 P.3d 217 (Okla. Civ. App. 2002).

¹⁵² See *supra* text accompanying note 84 (discussing *Cary* opinion).

¹⁵³ 84 Cal. Rptr. 2d 799.

¹⁵⁴ 58 P.3d 217.

¹⁵⁵ 68 P.3d 462.

rule of immunity in the aftermath of its rejection in states some states, some extensive analysis of *Sanchez* is required.¹⁵⁶

Sanchez was in the business transporting commercial machinery and had purchased cargo insurance from Lloyd's of London.¹⁵⁷ While moving a commercial dryer to a customer in Los Angeles, the dryer was damaged.¹⁵⁸ *Sanchez* made a claim under the policy for repair as soon as possible, with apparent agreement that the damage could be repaired in about a week for a cost of \$12,000.¹⁵⁹ Like many policyholders, *Sanchez* wanted things taken care of as soon as possible but he had a good reason beyond ordinary impatience.¹⁶⁰ The customer that was slated to receive the dryer was losing business every day that delivery was delayed.¹⁶¹ *Sanchez* informed Lloyd's through its independent adjuster of the need for speed in handling the claim in order to prevent huge losses from accumulating (thereby at least arguably making Lloyd's responsible for these additional

¹⁵⁶ 84 Cal. Rptr. 2d 799.

¹⁵⁷ See 84 Cal. Rptr. 2d at 800. More precisely, *Sanchez* had purchased cargo insurance from an underwriting syndicate at Lloyd's. *Id.* Although perhaps the most famous insurer in the world, Lloyd's is not actually an insurance company but is an exchange of sorts at which a number of underwriters operate as agents for syndicates that provide the financial backing for the operation. Typically, a prospective policyholder retains a broker in the United States (or elsewhere), who in turn contacts a Lloyd's broker, who arranges coverage through a Lloyd's underwriter. A similar process is followed for obtaining insurance from London Market insurers that might be analogized to an "off-Broadway" counterpart to Lloyd's. Consequently, where a policyholder sues for coverage, they are technically suing "Certain Underwriters" at Lloyd's rather than Lloyd's as an entity.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

damages and a *Hadley v. Baxendale*¹⁶² defense unavailable, at least if the insurer was in breach of the policy).¹⁶³

Apparently unmoved by Sanchez’s plight, the claims adjuster took three months “before the claim was paid and the repairs completed. As a result, the dryer’s purchaser sued and . . . obtained a judgment against Sanchez” for (I am not kidding) more than \$1,3 million.¹⁶⁴ Sanchez then sued Lloyd’s under the policy and sued the adjuster “on a negligence theory,” with the adjuster claiming immunity under the traditional lack-of-privity and disclosed agency defenses¹⁶⁵ seemingly well enshrined in California law.¹⁶⁶

¹⁶² (1854) 156 Eng. Rep. 145.

¹⁶³ Under the rule of *Hadley v. Baxendale*, (1854) 156 Eng. Rep. 145, a party breaching a contract is not liable for consequential damages unless they not only flow from the breach but are also within the contemplation of the parties at the time the contract is made. See DAVID EPSTEIN, BRUCE MARKELL & LAWRENCE PONOROFF, MAKING AND DOING DEALS: CONTRACTS IN CONTEXT 831-846 (2d ed. 2002); Farnsworth, *supra* note 10, § 12.14.

As a matter of contract law, Sanchez might have been out of luck because most courts hold that the consequential damages in question must have been reasonably foreseeable at the time of contracting rather than after the loss event. In addition, Lloyd’s could probably argue successfully that Sanchez should have come up with his own \$12,000 for dryer repair and mitigated the damages rather than waiting for three months while Lloyd’s and its adjuster apparently dithered. But even if consequential damages for the breach are not available, one can make a strong argument that taking three months to process an emergency claim after being put on notice by the policyholder constitutes bad faith and entitles the policyholder to damages (e.g., an adverse judgment by the customer) proximately resulting from the bad faith, provided that Sanchez’s failure to mitigate does not cut off the claim.

¹⁶⁴ 84 Cal. Rptr. 2d at 800.

¹⁶⁵ See *id.* By suing the adjuster on a negligence theory, which of course sounds in tort, Sanchez was probably trying to avoid the problems facing him in prosecuting the breach of contract claim against the insurer due to the *Hadley v. Baxendale* foreseeability problem and his failure to mitigate consequential damages. *Hadley v. Baxendale*, (1854) 156 Eng. Rep. 145.

¹⁶⁶ See *Egan v. Mut. of Omaha Ins. Co.*, 24 Cal. 3d 809, 824, 620 P.2d 141, 169 Cal. Rptr. 691 (1979); *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 576, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973), discussed at TAN 27-42, *supra*.

Sanchez begins as a noble effort of a busy state court to take an in-depth look at the problem. It even cites Cardozo's classic work of sociological jurisprudence *The Nature of the Judicial Process*.¹⁶⁷ But despite these pretensions, *Sanchez* quickly dissolves into what I term "pseudo-policy lite." This is the type of "analysis" that occurs when a court trots out non-doctrinal, seemingly prudential reasons for a ruling that are based primarily on assertion, illogic, poor reasoning, failure to consider other factors, or a misunderstanding of the manner in which either its rule or the rejected rule would operate. "Pseudo-policy lite" analysis pretends to be applying a real world appreciation of the collateral consequences of its decision making when it in reality is merely invoking over-simplified or misleading arguments that do not in fact square with reality.

Rather than basing its decision in favor of adjuster immunity upon California Supreme Court decisions pretty squarely on point (and which presumably controlled disposition of the case no matter how much commentators might criticize them),¹⁶⁸ the *Sanchez* Court chose instead to look at a relatively recent state supreme court decision limiting the liability

¹⁶⁷ See 84 Cal. Rptr. 2d at 800-801 ("While courts do not generally make broad policy in the manner of legislatures, they do make policy decisions in the "gaps," filling in the "open spaces" or "interstices" of the law." (citing CARDOZO, NATURE OF THE JUDICIAL PROCESS 113-14 (1921))). Courts deciding questions of duty are engaged in the limited "legislative" aspect of the judicial function. From this promising premise, the *Sanchez* Court immediately slides into analogy to other California cases rejecting liability and a prediction of adverse consequences from adjuster liability that betrays lack of understanding about the operation of insurance intermediaries in the field.

The *Sanchez* Court is right to note, as did the Cardozo Court, that courts must often make policy-based assessments in determining the reach of common law liability. But, for reasons that I hope are apparent in this section's discussion, it did a weak job of public policy analysis. One wonders why, in view of the existing California Supreme Court precedent in *Egan* and *Gruenberg*, the *Sanchez* Court did not just declare adjuster immunity as a matter of settled doctrine. If it had, it would have arguably better served the nation by not being a part of the counterattack against a possibly emerging rule of intermediary responsibility for misconduct.

¹⁶⁸ See *supra* text accompanying notes 25-29 (discussing Ashley's criticism of *Gruenberg* and similar analyses limiting intermediary liability on privity of contract grounds).

of auditors to third parties¹⁶⁹ and a 40-year old decision permitting a beneficiary's claim for lawyer malpractice regarding a will that resulted in financial loss to the beneficiary.¹⁷⁰ *Sanchez* analogized claims adjusters to auditors in making its adjuster immunity ruling and minimized the analogy of adjusters to attorneys in attempting to avoid a precedent imposing liability.¹⁷¹

Rather than relying on the settled state law of adjuster immunity, the *Sanchez* Court took it upon itself to apply a set of factors generally used to determine the existence of a tort duty. Although this may have made for a more Cardozo-like analysis for the Court, it was both unnecessary and misleading in that the liability of auditors, particularly if they preparing statements for the public or dispersal to third parties, is less problematic than suggested by the *Sanchez* Court. Indeed, in most states auditors are subject to liability under these circumstances.¹⁷² Although auditor liability

¹⁶⁹ See *Bily v. Arthur Young & Co.*, 834 P.2d 745, 760 (Cal. 1992) (discussed at *Sanchez*, 84 Cal. Rptr. 2d 800-802 (holding an auditor is liable only to clients, and not to third parties for negligent preparation of financial statement)).

¹⁷⁰ See *Biakanja v. Irving*, 320 P.2d 16, 18 (Cal. 1958) (discussed in *Sanchez*, 84 Cal. Rptr. 2d at 800-801 (holding a lawyer who renders a will void by negligently failing to have it properly witnessed owes a duty of care to the intended sole beneficiary)).

¹⁷¹ After citing the *Biakanj v. Irving* case and acknowledging that attorneys enjoy less protection from third party claims than do independent insurance adjusters, the *Sanchez* Court seemed unwilling to wrestle with those implications. See generally *Sanchez v. Lindsey Modern Claims Services Inc.*, 84 Cal. Rptr. 2d 799 (Cal. Ct. App. 1999). As discussed below, the degree of existing attorney liability to third parties makes a case for at least as much insurance claims intermediary liability to third parties. Lawyers stand in a significantly different position than do claims adjusters in terms of their role and the social interests at stake if they are made to compromise their traditional role of zealous fiduciary loyalty to the client that hires them. This could tag attorneys for liability that might, in part, be characterized as merely an outgrowth of steadfast loyalty to a mistaken client. In spite of this, lawyers generally, and in the insurance context in particular, are subject to significantly more liability exposure than independent claims adjusters under the *Sanchez* ruling, a fact that seriously calls into question the wisdom of the holding. See *infra* text accompanying notes 198-205.

¹⁷² See DOBBS, *supra* note 9, at § 480; RESTATEMENT (SECOND) TORTS § 552 (1977) (auditor liable to third parties if third party's reliance on auditor work was

may be established precedent in California, the minority status of this immunity is not a particularly strong public policy argument for a rule of auditor immunity.

If the rule of auditor immunity is correct, one's first reaction may be to apply it to adjusters as well. But first reactions can be deceiving. On one hand, Auditors are to some extent the "weights and measures" yardstick upon which much of the modern financial system depends.¹⁷³ The seeming failure of auditors in notorious business meltdowns of the early 21st Century brought on the Sarbanes-Oxley Act, which moved auditing more toward being a regulated industry than an independent, self-regulating profession.¹⁷⁴ Even widespread misfeasance by independent adjusters, TPAs and MGAs does not pose the same danger to the economy and is unlikely to produce the type of social upheaval or legislative response spurred by perceived auditor failure.¹⁷⁵

reasonably foreseeable). The contrary rule largely immunizing auditors from tort liability (but permitting recovery where the third party was an intended beneficiary of the contract between client and auditor) ironically stems from a famous Cardozo opinion. See *Ultramares v. Touche*, 174 N.E. 441 (N.Y. 1931). The opinion was subject to criticism almost immediately upon its issuance and over time most jurisdictions have found the *Ultramares* precedent to grant too much protection to accountants. It arguably is an opinion in which then-Judge Cardozo erred in filling in the uncertain interstices of the law. But, of course, to the extent that California follows the *Ultramares* rule, the *Sanchez* Court was bound to follow the *Ultramares* rule. However, this hardly gave the *Sanchez* Court license to engage in a wide-ranging attempt to analogize auditors to accountants when there already existed reasonably clear adjuster precedent in California.

¹⁷³ Ironically, the same Judge Cardozo, who was so resistant to auditor liability to non-contractual parties in *Ultramares*, had recognized years earlier that a scale operation serving the public was responsible for any injury caused by reasonable reliance upon the supposed accuracy of its measurements. See *Glanzer v. Shepard*, 135 N.E. 275, 275 (N.Y. 1922).

¹⁷⁴ See 15 U.S.C. §§ 7201-7266 (2006). See generally Jeffery D. Van Niel, *Enron – The Primer*, in *ENRON: CORPORATE FIASCOES AND THEIR IMPLICATIONS* 16-17 (Nancy B. Rapoport & Bala G. Dharan eds., 2004); MIMI SCHWARTZ WITH SHERRON WATKINS, *POWER FAILURE: THE INSIDE STORY OF THE COLLAPSE OF ENRON* 94-96 (2003).

¹⁷⁵ See, e.g., BARBARA LEY TOFFLER WITH JENNIFER REINGOLD, *FINAL ACCOUNTING: AMBITION, GREED, AND THE FALL OF ARTHUR ANDERSEN* 219-20

But more important is the degree of attenuation presented by auditor liability and adjuster liability. An auditor may perform work for a client and then, without its knowledge or permission, have that work shown to unknown third parties who later assert claims against the auditor when something goes wrong. In such cases, the auditors are truly being sued by complete strangers. By contrast, a claimant or a policyholder is hardly a stranger to the adjuster or TPA, even if there is not a formal contract between the adjuster and the claimant or policyholder. Consequently, the relation of auditors to potential claimants is quite distinct from that of claims adjusters and potentially much broader. Consequently, it hardly follows that if auditors are immune, adjusters must also be immune.

Despite these fairly dramatic differences, the *Sanchez* Court pressed the auditor analogy hard in arguing that imposing liability on adjusters would be a major breach of the principles of duty and tort law. “Like the auditors, the insurer-retained adjuster is subject to the control of its clients, and must make discretionary judgment call. The insurer, not the adjuster, has the ultimate power to grant or deny coverage, and to pay the claim, delay paying it, or deny it.”¹⁷⁶

While this is technically true, the insurer’s final say in calling the shots of claims resolution hardly make the adjuster a mere functionary. Independent adjusters have substantial impact on claims outcomes in that they provide the insurer with a factual investigation and analysis of the claim, usually making recommendations as to denial, valuation, and payment of a claim. This is a far cry from a hypothetical Cratchett of the 19th Century simply selling the wares of Marley to customer Dickens.

In addition, the relationship of insurer to policyholder also logically affects the relationship of the insurer’s agent to a claimant or policyholder. Insurers stand in quite a different posture to both their policyholders and even to third party claimants, than do ordinary contracting parties. The obligations of good faith and fair dealing that are often given a short shrift in much of the contract world (e.g., mere absence of fraud qualifies as good faith no matter how much a breaching party deprives the other of the benefit of the bargain) have real teeth when

(2003) (describing the closure of a famous accounting firm in light of criminal litigation and bad press stemming from its role as primary outside auditor to Enron).

¹⁷⁶ See *Sanchez*, 84 Cal. Rptr. 2d at 801-02.

applied to insurance. In some cases, an insurer may be held accountable for bad faith because of misconduct toward the policyholder even when it was not required to provide coverage.

Although third parties have fewer rights vis-à-vis the insurer, it is generally acknowledged that insurance has a public interest component as part of a system of social policy that requires at least reasonable behavior toward third parties. Although the insurer's well-known "duty to settle" is designed primarily to prevent the policyholder from facing uninsured liability, it also has elements of encouraging rational and expeditious dispute resolution so as not to unduly burden the state and society through litigation or other means.

The net result of all this is well-established legal doctrine that requires that an insurer not favor its own interests above the policyholder's.¹⁷⁷ Logically, this also requires that an independent adjuster or MGA may not favor the insurer's interest at the expense of the policyholder, and that the adjuster fairly, accurately, and competently evaluate claims against a policyholder that have invoked the insurer's duty to defend and settle. Because the insurance intermediary is not an agent acting as a mere conduit or solicitor, the intermediary logically has duties of reasonable care and fair dealing approaching that of the insurer. Further, those duties logically are owed to the policyholder as well as to the insurer since the adjuster has stepped into the shoes of an insurer that must give equal consideration to the rights of the policyholder in resolving claims.

In arguing that the insurer's final decision making authority excuses any intermediary responsibility to others, *Sanchez* failed to consider the nature of the intermediaries tasks and the nature of the insurance arrangement. *Sanchez* then made the argument that:

[w]hile the insurer's potential liability is circumscribed by the policy limits, and the other conditions, limits and exclusion of the policy, the adjuster has no contract with the insured and would face liability without the chance to limit its exposure by contract. Thus, the adjuster's role in the claims process is "secondary," yet imposing a duty of care could expose him to liability greater than faced by his principal the insurer.¹⁷⁸

¹⁷⁷ See STEMPER ON INSURANCE CONTRACTS, *supra* note 27, at § 10.03.

¹⁷⁸ See *Sanchez*, 84 Cal. Rptr. 2d at 802.

This argument seems both odd and empirically incorrect in that it takes the absence of traditional contract privity and instead of using it as a doctrinal defense attempts to turn it into a policy argument in favor of intermediary immunity. Although it probably should get points for creativity, it is wrong about the law. Although it is true that insurer coverage liability is generally restricted to the policy limits of the insurance in question, it is not true that this provides an ironclad safe harbor against further insurer liability.

Insurers may often be required to pay counsel fees or interest upon losing a coverage determination. They of course may also be responsible for incidental and consequential damages for failure to properly process a covered claim. Although this extra-limits liability is rare where the insurer has acted reasonably, volitional, unreasonable insurer conduct amounts to bad faith under the law of most states and makes these damages available to the policyholder (and often its assignees). For example, where a liability insurer (in California and most states) unreasonably fails to accept a settlement offer, the insurer is responsible not only for paying the policy limits, but also any judgment amount against the policyholder in excess of policy limits. Where the insurer's bad faith or other misconduct was the product of willful indifference to the rights of the policyholder, the insurer may be held liable for punitive damages.

In short, it simply is not true that insurers enjoy significantly more ability to limit their liability than do claims intermediaries. Under these circumstances, it is just plain strange that a court would feel itself compelled to declare immunity for these intermediaries on the ground that the absence of formal contracting somehow makes the adjuster's lot worse than that of the insurer.

The *Sanchez* Court also argues that since “[a]n adjuster owes a duty to the insurer who engaged him,” a “new duty to the insured would conflict with that duty, and interfere with its faithful performance. This is poor policy.”¹⁷⁹ Actually, it is poor analysis by the court. The claims

¹⁷⁹ *Id.* (citing *Gay v. Broder*, 167 Cal Rptr. 123, 127 (Cal. Ct. App. 1980) (holding a home appraiser owes no duty of care to a home loan borrower because this would subject the appraiser to a conflict with the duty owed to the lender retained by the appraiser); *Felton v. Schaeffer*, 279 Cal. Rptr. 713, 716 (Cal. Ct. App. 1991) (holding a doctor hired by an employer to conduct a pre-employment physical owes no duty to the applicant); *Keene v. Wiggins*, 138 Cal. Rptr. 3, 7 (Cal. Ct. App. 1977) (holding a doctor used by a workers' compensation insurer to assess the alleged disability of an employee did not owe the doctor-patient duty of an accurate diagnosis to the employee)).

adjuster represents the insurer. By law, the insurer cannot give regard only to its own interests; it must not only consider the interests of the policyholder but give them at least “equal” consideration, a legal rule internalized in the custom and practice of insurance (where adjusters frequently describe their role as being required to “look for coverage” rather than “look for reasons to deny coverage”). The adjuster, like the insurer, therefore already has obligations to the policyholder. By immunizing the adjuster from a damages action, the *Sanchez* Court merely deprived the policyholder of a legal right that it already possessed, *i.e.*, a right to have the adjuster act in the same manner as the insurer is required to act.

More practically, the experience of decades of insurance claims adjustment in the field has already demonstrated that, despite the occasional glitches that produce coverage and bad faith litigation, insurers (and their intermediaries) generally do a reasonably good job of balancing the interests of policyholders against their own economic interests. Attorneys retained by insurers are often particularly exemplary in this

For what I hope are reasons obvious to the reader, if not the *Sanchez* Court, these cases are inapposite to the issue of insurance claims intermediary liability. Recall that the adjuster stands in for the insurer, which is obligated to give equal consideration or even priority to the interests of the policyholder. By contrast, the home appraiser has only one interest: making sure that the home is not overvalued so that the bank does not loan more money for purchasing the house than is justified by the fair market value of the home.

Regarding doctors, the *Felton* and *Keene* cases, cited above, correctly state the historical rule but like the tradition of adjuster immunity, the tradition of doctor immunity is under attack and will, with luck, eventually fall. Physicians are publicly licensed professionals accorded substantial privileges that historically have also demanded at least some commitment to the public interest. They also swear a Hippocratic Oath in favor of assisting life and health when they can reasonably do so. It is borderline obscene to suggest that a doctor examining a job applicant or a workers compensation claimant has absolutely no obligation to notice obvious health problems and report them to the person under examination so that the person may obtain appropriate follow-up care – even if the person examined is technically not the doctor’s “patient.” The medical analogy to insurance intermediary liability is explored at *infra* text accompanying notes 201-202. *See also* Spaulding v. Zimmerman, 116 N.W.2d 704, 709-10 (Minn. 1962) (vacating a settlement in a case where defense lawyer learned of plaintiff’s life-threatening medical condition through Civil Rule 35 independent medical examination and failed to make disclosure).

regard, arguing for the best interests of the policyholder even though it is the insurer that is paying the bills and the insurer that the attorney hopes will send additional business in the future.¹⁸⁰

The strongest policy argument invoked by the *Sanchez* Court was the contention that “[t]he deterrent effect of imposing a duty on adjusters is questionable” because “[a]djusters are already deterred from neglect by exposure to liability to the insurer who engaged them, for breach of contract or indemnity.” According to the Court, “[o]nly some modest additional deterrence, at most could be expected from imposing a new duty owed directly to insureds.”¹⁸¹ Although *Sanchez* acknowledged that “[i]mposing a duty also might benefit insureds by providing another source of recovery for injuries caused by negligent claims handling or investigation” the Court viewed this as “redundant” (in “most cases”) because the insurer would also be liable for the adjuster’s mistakes and “[t]hus making the adjuster directly liable to the insured would, again, confer only a modest additional benefit.”¹⁸²

Critical as I am of *Sanchez* and similar cases, I concede that this argument had some force even if the court’s exposition of its rationale is a little melodramatic. For example, the court went on to note:

Insurance is a highly uncertain and risky endeavor, because it requires accurate predictions about the occurrence and cost of future events. Insurers are able to define and limit the risks, and to set premium levels commensurate with the risks, using complex and nuanced contracts (policies). By contrast, adjusters hired by insurers have no contract with insureds, and thus no ability to define or circumscribe their potential risks or liabilities to insureds. If adjusters faced negligence liability to insureds, market forces would tend to drive adjusting activities in-house, where they could be shielded with contractual exclusions, disclaimers, and limitations. Thus,

¹⁸⁰ See *infra* text accompanying notes 198-204 (comparing the role and liability of attorney intermediaries to that of claims adjusters).

¹⁸¹ See *Sanchez*, 84 Cal. Rptr. 2d at 802.

¹⁸² See *id.*

imposing a duty would reduce, perhaps severely, the offering of independent adjuster services. Yet widespread market acceptance has shown these services to be useful and desirable.

Those adjusters continuing to operate independently despite imposition of a new duty of care would attempt to buy insurance against this liability, or create their own cash reserves, adding these costs to their charges, and passing them on to the insurers who used the adjusters' services. These insurers, in turn, would add the cost to the premium charged to insureds. The insured thus would end up paying more for insurance without obtaining more value because, as noted above, adjuster liability would provide only a redundant source of recovery usually available from the insurer.¹⁸³

Stripped of the excessive gloom-and-doom or parade-of-horribles rhetoric, the *Sanchez* Court is merely asking the rhetorical question: if the insurer ultimately is liable to the wronged policyholder, why does the policyholder also need a cause of action against the adjuster? It's a good rhetorical question, but not good enough to support continued adherence to a broad and inflexible norm of claims intermediary immunity.

It is also important to remember that (Cardozo, sociological jurisprudence, and legal realism notwithstanding) courts are primarily supposed to be deciding cases with reference to existing doctrine and case-by-case required modifications of doctrine rather than sweeping quasi-legislative public policy pronouncements and predictions such as those quoted in the passages quoted above. This portion of *Sanchez* reads like a legislative committee report more than a judicial opinion. But legislative committee reports are generally based on at least some fact finding through receipt of hearing testimony, staff research, and review of public comment submissions (although partisanship and interest group influence of course play a role). This portion of *Sanchez* reads as though it was taken verbatim from the musings of the adjuster's brief. It was rendered without supporting citation and is in part self-refuting, for the reasons discussed below.

¹⁸³ See *id.*

To the extent that courts inevitably make some decisions on the basis of public policy rather than application of existing doctrine or the doctrinal refinements that result from treating like cases alike, *Sanchez* is still unsatisfying because it embraces (without benefit of electoral mandate) a view of public policy that is unduly protective of intermediaries for reasons that appear empirically incorrect. The object of law is not simply to provide some avenue for recompense when wronged (a view that might support *Sanchez*'s contention that one responsible potential defendant is enough). Rather, a rational legal regime should provide not just some incentives for good behavior but optimal incentives that accurately reflect the commercial and behavioral reality of the activity under scrutiny well as taking account economic reality.

On the economic reality score, the “no need for additional deterrence or compensation sources” rationale is not nearly as strong as suggested by the *Sanchez* Court. Although insurers do not fail with the seeming regularity of subprime mortgage lenders, dot.com start-ups, or restaurants, insurer insolvency is a real danger. If it occurs, the policyholder (or its proxy) may very well not be able to obtain recompense. Imposing liability in apt cases upon claims intermediaries does not unfairly create a deeper pocket for compensation but instead provides an alternative pocket that provides additional protection if the insurer is unable to pay the claim.

There may even be cases in which a reasonable adjudicator could find the claims intermediary to have liability even though the insurer does not. Had it been permitted to be litigated in full, *Sanchez* itself might have been such a case. Recall that the policyholder faced some significant coverage issues and arguably had failed to mitigate his contract damages. However, under the (admittedly rare) right set of circumstances, the adjuster might logically be held liable for tortuous conduct outside of the terms of the insurance policy, just as many jurisdictions permit recovery for bad faith treatment even when coverage did not exist or was doubtful.

But the risk that insurers will escape liability through insolvency is not the primary problem with the *Sanchez* view that adjuster liability is not necessary for reasonable deterrence. More problematic is that adjuster and insurer incentives are often misaligned in a manner that does not by any means ensure that in the event of policyholder mistreatment by the adjuster, the insurer tagged with responsibility will pursue the adjuster, thus creating sufficient consequences to in turn provide an adequate incentive for the adjuster to treat policyholders fairly.

In real life, the insurer, even though perhaps facing liability for adjuster wrongdoing, may be perfectly happy to have the adjuster taking

sharp, unreasonable positions with the policyholder. If the insurer itself behaved directly in this fashion toward the policyholder, it would be at substantial risk of a bad faith judgment. Although the insurer remains responsible for most agent activity within the scope of the agency, juries might well tend to be more forgiving of the insurer in cases where the most egregious misconduct is committed by the independent contractor agent rather than the insurer itself.

Intermediary immunity allows insurers and their claims agents to engage in at least occasional episodes of “good cop/bad cop” in which the insurer portrays itself as very concerned for the policyholder, but unaware of adjuster misconduct or unable to control it because of the adjuster’s independence and distant operations. Even if a reviewing jury finds severe misconduct by the adjuster, it may be reluctant to find bad faith by the insurer and award substantial damages to the insurer, when the insurer has not been actively engaged in wrongdoing. The adjuster agent dilutes any negative picture a jury might have of the insurer, but the adjuster itself cannot be held responsible for its active misconduct, even though jurors might well be diverted from focus on the insurer (either as principal or passive wrongdoer) because of the adjuster’s active misconduct.

If nothing else, the buffering effect of the immune adjuster agent logically makes it far less likely that a jury will impose punitive damages on the insurer. Although the court can painstakingly instruct the jury that the insurer is responsible for the bad acts of the adjuster, but this hardly has the same force as seeing the insurer itself act with willful indifference to policyholder rights.

When *Sanchez* asserts that the “widespread market acceptance” of outsourcing the claims function demonstrates the utility and desirability of this delegation of insurer function, the court wrongfully forgets to ask whether this is good or bad for the policyholder. Insurers might indeed prefer to outsource the claims function – but this can be for reasons that are either good (cost-savings, expertise, flexibility) or bad (cheaper because shoddier, insulation of the insurer, a reflection of reduced concern for fair claims treatment). Insurers may find independent contractor adjusters “useful and desirable” but this hardly means they are good for policyholders. Further, regardless of whether outsourcing the claims function is good or bad on the whole, each individual policyholder is entitled to be treated fairly by whoever adjusts the claim.

The *Sanchez* Court is probably wrong in predicting that removing absolute immunity for independent intermediaries would drive the adjustment function significant more in-house for insurers. If independent adjusters are a money-saver for insurers, they will be inclined to continue

following this business model, even if some of the savings are lost because of imposition of adjuster liability that will be spread and potentially passed on to policyholders.

But even if this *Sanchez* argument is correct, it hardly follows that a return to in-house claims adjusting is a bad thing. Returning more of the claims function to the insurer might well improve claims practices by creating a culture of improved incentives and concern for policyholders. It is at least plausible that outsourced adjusting (particularly when coupled with immunity) leads to lowered standards and a more short-sighted attitude toward the treatment of policyholders and others.

The independent adjuster arguably has a considerably more short term perspective on the process than the insurer that both must live with the results and wants to enjoy good public relations for customer retention, future marketing, and the insurer’s anticipated receipt of premium payments from a satisfied customer who stayed with the company, because the insurer treated the policyholder fairly during the claims process. The very leanness and meanness of some independent adjusters that produces cost savings can contribute to shortcuts and slipshod claims processing. Adjustment by the insurer itself may cost more in initial operation but bring better results, both in terms of legal fairness and long-term cost savings stemming from reduction in disputes.

In addition, this portion of the *Sanchez* public policy analysis posits that removing immunity for disclosed agent adjusters would impose substantial additional costs on the claims resolution process. The *Sanchez* Court reasons as follows: liability for the intermediary will raise disputing and liability costs; this in turn will raise adjuster fees and insurance premiums; and therefore intermediary liability is bad. But this syllogism is far from self-evidently correct.

In a competitive market, particularly a “soft” insurance market, there may be enough adjusters competing for business that they will absorb the relatively modest cost of liability insurance spread through the overall pricing of their book of business. Alternatively, independent adjusters may be able to increase their fees, but insurers may not be able to pass these along (at least not completely or perhaps not substantially) as this risks losing market share to competitors.

More importantly: an increase in adjuster fees and insurer premiums is not necessarily bad if it results in better adjusting of claims and greater insurer supervision of adjusters and more reasonable adjuster and insurer behavior toward policyholders and claimants. Although no one wants unaffordable or unavailable insurance, low premium insurance is of little or no real value if the insurer and its claims intermediaries fail to

accord apt treatment to policyholders and claimants. In addition, there is considerable social cost if insurance error leads to economic waste, dislocation, or intervention (*e.g.*, public assistance for the unfortunate policyholder who should have been protected by insurance that it had purchased).

There is considerable wisdom in the adage that “you get what you pay for.” The *Sanchez* Court wrongly assumes that lower costs for vendors is always good (irrespective of their performance and incentives) and that expansion of liability is always bad. The tradition of disclosed agent immunity stems from the Dickensian time of Marley, but in its modern form bears more resemblance to Scrooge. Essentially, the *Sanchez* Court is implicitly arguing that the simple fairness of holding adjusters accountable for the damage they inflict on policyholders or claimants is a burden victims should simply bear for the supposed greater overall good of hypothesized lower adjuster fees and insurance premiums.

More important, *Sanchez* overlooks that the insurer’s chief duty is not to make insurance premiums as low as possible. Rather, the main obligation of an insurer is to the policyholder suffering a potentially covered loss. The insurer is required to act reasonably and give equal consideration to the interests of the policyholder in adjusting the loss. If doing this results in premium increases or contraction of future sales, this is simply the price to be borne for honoring the insurer’s greater duty of care to the vulnerable policyholder seeking coverage and for providing a better insurance product.¹⁸⁴

By extension, this analysis requires that the independent intermediary employed by the insurer be subject to the same hierarchy of

¹⁸⁴ In a recent advertising campaign, State Farm expressly touts its performance in providing coverage as of higher quality while being “about the same price” as other insurers. In what may have been an unfortunate harbinger of the team’s 2008-2009 season, one commercial features Seattle Seahawks quarterback Matt Hasselbeck getting pass protection from a group of 80-pound Pop Warner league lineman (representing a Brand X insurer), with the predictable result that he is sacked. This is contrasted with another scene in which a group of gigantic lineman (representing State Farm) provide Hasselbeck with sufficient protection to complete a pass. The ad campaign is a fairly direct attempt by State Farm to sell “service-after-the-sale” (and perhaps solvency as well) in trying to persuade prospective buyers not to select an insurer by premium price alone. This sales pitch from the nation’s largest insurer is at least in tension with the *Sanchez*’s courts “lower costs are the greatest good” contention, if not an outright refutation of that contention.

duties and set of obligations imposed on the insurer. Refusing to impose substantially similar burdens on the claims intermediary undermines the effective operation of the insurance market. While one can contend that there is sufficient adjuster discipline because the adjuster must answer to the insurer, this is a weak argument. The insurer hired the adjuster for a reason – to outsource the job of handling claims. Realistically, the insurer will rely heavily on the adjuster’s investigation and assessment (unless the insurer is outsourcing the function so that the adjuster can be the insurer’s “bad cop,” which is an even more troublesome scenario). The adjusters’ good or bad conduct will have significant impact on claims decisions, all with relatively little supervision by the insurer. This strongly argues for holding claims intermediaries to the same standards imposed on insurers.

Further, as discussed above, the insurer is not nearly as likely to punish adjuster misconduct as was posited by the *Sanchez* Court. One reason is that adjusters can run de facto interference for the insurer. Far from punishing errant adjusters, insurers may enjoy the degree to which an aggressive anti-coverage, low-payment adjuster increases insurer profits while providing a useful (but immune) foil in the comparatively few cases that result in litigation of any sort, much less bad faith or punitive damages litigation.

In addition, because insurer sales, marketing, underwriting, and claims departments often seem to act without much knowledge or coordination among themselves, there is the practical reality that even a pretty sloppy independent intermediary will continue to be used by the insurer unless something (a) goes really wrong and (b) comes to the attention of the proper person who can hire and fire intermediaries under circumstances where (c) the errant adjuster is not on the whole making money for the insurer. If proposition (c) obtains happens, the insurer is unlikely to seek indemnification for cases in which the adjuster’s misconduct toward a policyholder resulted in insurer liability. Many insurers would view this as simply straining relations with a useful business partner and prefer to seek recompensation through some informal adjustment of pricing in future claims business.

In much the same way that a hospital may be tempted to turn a lax eye toward malpractice suits against a doctor who performs many procedures and generates considerable revenue, the insurer will most likely not take aggressive action against the adjuster even where the adjuster’s attributed misconduct results in the insurer paying a claim, particularly where the claim was one the insurer was required to pay in any event (which is usually the case). Only in cases of where bad faith/punitive damages liability significantly exceeds policy limits is the insurer likely to

be very bothered by intermediary error. In short, even the strongest of the public policy rationales of *Sanchez* and similar decisions is unconvincing.

Sanchez is also awash in statements that suggest the court had an underappreciation of the nuances of insurance concepts and insurance in operation. As noted in the extensively quoted passages above, the court seems to favor immunity for intermediaries because it seems them as the analog to mom-and-pop grocery stores under attack from supermarkets. To the *Sanchez* court, any contraction of the business of independent adjusting and any movement toward adjusting by the insurer's own employees is a step in the wrong direction. But just as the supermarket is generally seen as an improvement over the corner grocery store (and remains a superior alternative to 7-Eleven and its counterparts), it might improve insurance adjusting if the small independents were replaced by larger, more professional organizations operated by the insurers themselves.

In addition to turning the concept of privity on its head (so that the absence of contract not only protects the adjuster from a contract-based claim but also makes imposition of tort liability unfair), *Sanchez* also converts the notion of reasonable expectations from a concept generally favorable to policyholders to one favoring adjuster immunity because "[a] new rule would defeat their reasonable expectations."¹⁸⁵

Further, recognition of "[a]djuster liability would be an empty slate, upon which the courts would have to write a whole new body of 'adjuster liability' law" without the benefit of "contracts devised by knowledgeable and imaginative private parties to give structure to the risks" resulting in years of development of law in the area.¹⁸⁶ This part of *Sanchez* is a little shocking in that it seems to argue that courts should be reluctant to recognize defendant liability simply because this will increase the workload of the courts.

By this rationale, one might argue for complete abolition of all liability irrespective of the question of individual rights and the social benefits of court-imposed liability and enforcement. Or, to cite some less extreme examples from real life, one might note that recognition of rights such as anti-discrimination, desegregation, one person/one vote, arrestee rights and manufacturer liability for unsafe products, all required courts to devote subsequent judicial resources to developing these emerging bodies

¹⁸⁵ See 84 Cal. Rptr. 2d at 803.

¹⁸⁶ *Id.*

of law. But this was never seen by the judiciary as a reason to refrain from doing what the court otherwise viewed as the legally proper thing and recognizing the basic right in question.

Similarly, the court’s desire to have “knowledgeable and imaginative private parties”¹⁸⁷ provide guidance begins to make it look all the more as though a main underpinning of *Sanchez* was abdication of the judicial function. Courts have for centuries developed the contours of duty and breach necessary to apply tort law. They hardly need contract draftsman from the insurance or intermediary industries to guide them in fleshing out the contours of claims intermediary liability.

In addition, there is nothing to prevent insurers, intermediaries, or other entities affected by any new rule of liability from doing their own contracting around the new legal regime through indemnity agreements or the like. *Sanchez* wrongly assumes that the announcement of a tort law rule removing absolute immunity for intermediaries would forever freeze the operations of participants in the insurance marketplace. On the contrary, a tort law rule of no adjuster immunity would be, like most legal rules, a default rule to which market participants could adjust (through contract and other means).

Also problematic is *Sanchez*’s deployment of the case law on the question of intermediary immunity. Predictably, *Sanchez* cites several cases illustrative of what it correctly regards as the majority rule, but it makes little effort to grapple with contrary precedent. New Hampshire’s 1986 *Morvay*¹⁸⁸ decision, an opinion at loggerheads with much of the *Sanchez* pronouncements, is not even cited. The 1980 Alaska decision of *Continental v. Bayless and Roberts* is cited but given unfairly and deceptively short shrift by *Sanchez*, which characterizes the rather pathbreaking *Bayless* case as “simply “rel[ying] on an earlier Alaska case” imposing liability on an agent.¹⁸⁹

By contrast, the Oklahoma Court of Appeals opinion in *Brown v. State Farm*,¹⁹⁰ makes considerably more persuasive public policy

¹⁸⁷ *Id.*

¹⁸⁸ See *Morvay v. Hanover Ins. Cos.*, 506 A.2d 333 (N.H. 1986).

¹⁸⁹ See *Sanchez*, 84 Cal. Rptr. 2d at 803.

¹⁹⁰ See *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217 (Okla. Civ. App. 2002).

arguments in favor of at least permitting adjuster liability. In *Brown*, plaintiffs were homeowners seeking coverage after two March 2000 fires damaged their property, claiming losses of more than \$60,000.¹⁹¹ The insurer retained an independent investigator that “concluded, “without interviewing either Brown or any of the fire-fighters involved, that there was only one fire, and that it resulted from ‘the deliberate act of a person or persons’” and that some claimed damage predated the fire.¹⁹² Perhaps unsurprisingly, the investigative report was a significant factor in the insurer’s decision to deny the claim.¹⁹³

Brown sued both State Farm and the independent investigator, settling with the insurer and continuing its claim against the adjuster, presumably for losses that were not sufficiently compensated from the funds paid by the insurer in settlement.¹⁹⁴ Thus, *Brown* provides an immediate example that, contrary to the assertions of Sanchez, it may well be practically useful to have liability potentially applicable to more than one entity involved in claim denial. In this sense, the removal of absolute immunity for independent intermediaries can be an effective means of providing more protection, spreading risk more widely, and facilitating greater settlement of disputes.

Comparing the adjuster’s situation to that of others who could be liable to reasonably foreseeable third parties, the *Brown* Court saw nothing jarring about removing investigator/adjuster immunity.¹⁹⁵ Because the policyholder presenting a claim to the adjuster is so obviously someone who could be hurt by poor performance of the adjuster’s duty, the *Brown* Court had no problem finding that there was adequate foreseeability sufficient to create a tort law duty owed the policyholder by the adjuster.

¹⁹¹ *Id.* at 218.

¹⁹² *Id.*

¹⁹³ *Id.* (case states that the decision was “based at least in part on this report”).

¹⁹⁴ *Id.*

¹⁹⁵ In particular, the court considered attorneys, sellers of intoxicating beverages, and individuals engaged in a love/lust triangle as having duties to those who could reasonably be injured by their conduct, citing Oklahoma case law in support. *See* 58 P.3d at 219-22.

Brown was assisted in its decision by Oklahoma’s different law regarding immunity for auditors. Unlike California, which follows the limitations of *Ultramares v. Touche*,¹⁹⁶ Oklahoma had for some time rejected *Ultramares* and embraced the broader liability rule of Restatement §552,¹⁹⁷ at least regarding negligently supplied information.¹⁹⁸ According to the *Brown* Court, it “was reasonable” for the policyholder “to expect that State Farm, through its [sic] agent JJMA/Cooper, would perform a non-negligent investigation of the fire. Indeed, it is indisputable that ‘both the insured and the insurer [had] a stake in the outcome of the investigation.’”¹⁹⁹

The jurisprudence of adjuster immunity generally suffers from an underappreciation of the degree to which the incentives of insurer and adjuster are insufficiently aligned with those of the policyholder (to whom a duty of good faith is owed) and others to whom tort-like duties of care are logically owed. As discussed above, under the current regime, the insurer can to some extent use the independent adjuster to “do its dirty work” with no liability risk to the adjuster and reduced bad faith and punitive damages risk to the insurer. This potentially creates a huge practical loophole in the law of bad faith that is supposed to provide adequate protection to policyholders. It also can create problems for other participants in insurance markets, as illustrated below. Put simply, without facing liability

¹⁹⁶ See 174 N.E. 441, 447 (N.Y. 1931) (accountants not liable to third parties for damages resulting from poor auditing, which was seen as breach of duty owed the client but not a basis for tort liability to third parties, even those whose reliance on the audit was reasonably foreseeable).

¹⁹⁷ See, e.g., *Stroud v. Arthur Andersen & Co.*, 37 P.3d 783, 793-94 (Okla. 2001).

¹⁹⁸ See Restatement (Second) of Torts § 552 (1977):

One who, in the course of his business, profession or employment, or in any other transaction in which he has a pecuniary interest, supplies false information for the guidance of others in their business transactions, is subject to liability for pecuniary loss caused to them by their justifiable reliance upon the information, if he fails to exercise reasonable care or competence in obtaining or communicating the information.

¹⁹⁹ See 58 P.3d at 222 (citing *Morvay*).

itself, the claims intermediary simply lacks sufficient incentive to engage in an optimal level of care toward policyholder's and others.

Sanchez and other modern cases defending intermediary immunity claim that there already exists adequate incentive for care because of the principal's potential contract claims against an intermediary who errors. As previously discussed, this contention has problems even as a matter of theory. As a matter of empirical evidence, the theory also seems infirm. Although the case reports are not awash in suits against intermediaries, they at least allege some very slipshod and wrongful conduct that should probably never occur if the theory of adequate policing by insurer principals is accurate.

For example, in *Aslakson v. Gallagher Bassett Services, Inc.*,²⁰⁰ the state Department of Workforce Development retained the defendant as a claims manager and TPA for the state's Uninsured Employers Fund.²⁰¹ Although the case focused primarily upon the degree to which the TPA might share the employer's immunity under state workman's compensation law, it is instructive in illustrating the degree to which claims intermediaries can engage in egregious misconduct and the utility of holding them accountable under such circumstances.

Plaintiff worked as a carpenter.²⁰² In July 1998, he fell 18 feet while working on a pole barn and sustained serious injury.²⁰³ His employer lacked worker's compensation insurance, forcing him to make a claim with the Uninsured Employers Fund in January 2000 (after apparently receiving medical care and other benefits in the interim, the source of which is unclear from the opinion).²⁰⁴ Despite what seems a clearly work-related serious injury without employee misconduct, the TPA denied the claim.²⁰⁵ It then required that the worker have in independent medical

²⁰⁰ 729 N.W.2d 712 (Wis. 2007).

²⁰¹ *Id.* at 714.

²⁰² *Id.* at 715.

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.*

examination.²⁰⁶ The March 2000 exam, while finding lower disability levels than claimed by the worker, confirmed temporary and permanent disability and “clearly entitled the plaintiff to worker’s compensation benefits.”²⁰⁷

But despite repeated requires, the TPA did not pay the benefits, even though its own vocational expert conceded up to a 10 percent loss of earning capacity due to the worker’s injuries.²⁰⁸ As of September 2001, benefits remained unpaid.²⁰⁹ The worker pursued administrative relief, which resulted in an administrative law judge (ALJ) order that the TPA pay approximately \$100,000.²¹⁰ But the TPA released only \$4,000 from the state Fund and “refused to pay the remainder of the award,” forcing the injured worker to seek additional review.²¹¹ In May 2002, the state’s Labor and Industry Review Commission adopted the ALJ’s findings.²¹² Rather than pay, the TPA sought judicial review, which resulted in court affirmance of the administrative decision in December 2002.²¹³ The TPA again refused to pay and sought further review, resulting in a September 2003 decision in favor of the worker.²¹⁴ “Only then did [the TPA] finally pay the balance of the plaintiff’s claim.”²¹⁵

Although finally paid, the worker was not mollified, and brought a bad faith action against the state Fund and the TPA, claiming (with

²⁰⁶ *Aslakson*, 729 N.W.2d at 715-16.

²⁰⁷ *Id.* at 716.

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Aslakson*, 729 N.W.2d at 716..

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*

seemingly good reason in light of the case history) that there was never any reasonable basis for contesting the claimed benefits (or at least not 96% of them) and “that the appeals were taken merely to delay payment of rightfully owed benefits.”²¹⁶ The Fund and TPA defended on grounds of immunity under the state Worker’s Compensation Act, a defense the trial court rejected as to the TPA.²¹⁷ The intermediate appellate court reversed, but the Wisconsin Supreme Court, in a persuasive opinion centered primarily on statutory construction, ruled that the state’s worker’s compensation law did not immunize the TPA and that plaintiff’s bad faith action could proceed.²¹⁸

Apparently, there was no question under Wisconsin law that, in the absence of statutory immunity, the claim could be brought against the TPA notwithstanding lack of privity of contract and the TPA’s status as a disclosed agent of the Fund.²¹⁹ The Court viewed the claim as permissible (in the absence of worker’s compensation immunity) under Wis. Stat. § 102.18(1)(b) “which provides a penalty for bad faith conduct” in worker’s comp claims.²²⁰ Consequently, *Aslakson* is not, strictly speaking, a case either embracing or rejecting common law immunity for claims intermediaries. In spirit, however, *Aslakson* is more aligned with cases rejecting intermediary immunity than with cases following the historical rule.

More important for purposes of this section, *Aslakson* illustrates the degree to which claims intermediaries can engage in pretty outrageous conduct and that they, in the absence of liability, have relatively little incentive to treat claimants fairly. Recall that the TPA in question was taking the position – one rejected by an ALJ, an administrative review board, and a trial court – that a carpenter could fall 18 feet and suffer only \$4,000 worth of permanent partial injury. Although the intermediate appellate court mysteriously granted more leeway to the TPA, the

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Aslakson*, 729 N.W.2d at 717, 728.

²¹⁹ *See Id.* at 719.

²²⁰ *Id.*

Wisconsin Supreme Court overwhelmingly agreed with the assessment of the ALJ, review board, and trial judge.

The bad faith claim in *Aslakson* centered on the TPA's recalcitrance in prosecuting appeals, one can make a strong argument that even its initial position forcing the ALJ decision constituted bad faith. The TPA's own vocational expert concluded that Mr. Aslakson had incurred a 10 percent decline in earning capacity because of the injuries from the fall. Even a lazy or bad carpenter will earn a lot more than \$40,000 in what remains of working life but the TPA was willing to pay only \$4,000 after the ALJ decision, and refused to pay anything prior to the ALJ order. On its face, the TPA's conduct looks unreasonable, yet the TPA was unwilling to give apt concern to the worker's interest and was unwilling to re-evaluate its hostile stance in light of mounting factors favoring payment.²²¹

Even if Aslakson had been a white collar worker and not suffered neurological impairment in the fall, the TPA's assessment would have been extreme. Applied to a claimant whose livelihood depends on his physical health, strength, endurance and dexterity, the TPA position seems ridiculous on its face. One need not be a cynic to perceive the TPA's conduct as merely running out the clock on the claimant in hopes of either forcing a settlement at a reduced amount or allowing the further investment income to the Fund.

As discussed above, insurers are often attracted to TPAs who engage in such conduct because it can be profit-enhancing for the insurer without the carrier itself sullyng its hands through directly connected bad faith treatment of the policyholder. Under the traditional rule, the TPA acts with impunity toward the policyholder/insured/claimant, no matter how unreasonable or evil its conduct.

In the context of the *Aslakson* case itself, the incentive structure is even worse because the state Fund is immune and lacks incentive to punish the TPA for misconduct since the Fund will not suffer any adverse conduct from the TPA's wrongdoing – even though the Fund may enjoy economic gain because of that wrongdoing. If the TPA is also immune, the victim is left without remedy. Although the worker's compensation or sovereign

²²¹ In contrast to the TPA position, the ALJ decision seems reasonable on its face. A carpenter of relatively young age could easily earn \$1 million in gross income over his remaining working life. Ten percent of that amount produces the \$100,000 award. Although a significant sum, it does not facially seem misaligned with the facts of the case.

immunity situations give particular illustration to the problems created by intermediary immunity, private insurance presents much the same situation with only the salve that the victim will usually have at least some claim against the insurer as principal.

Although the primary victims of claims intermediary error (or at least the victims without recompense)²²² are policyholders and claimants seeking recovery, insurers who are not the principals of an intermediary may on occasion suffer harm due to the intermediary's misconduct. In such cases, the rule of intermediary immunity also needlessly shields intermediaries and too greatly reduces the intermediary's incentive to take adequate care and to make a reasonable assessment of a claims situation. This imposes costs not only on the affected insurers, policyholders, and claimants but also can impose substantial externalized costs on the judicial system and society.

A fascinating (but one hopes rare) illustration of the far-reaching mischief of intermediary immunity is a case that began as *First Specialty Insurance Corporation v. Ward North American Holding, Inc.*²²³ and ended as *First Specialty Insurance Corporation v. Novapro Risk Solutions, LP*.²²⁴ The case started out simply enough with a barroom brawl in which one of the patrons was severely injured.²²⁵ Actually, it was more of an unprovoked attack rather than an escalating feud between patrons.²²⁶ The attacking group had set upon another patron earlier in the evening, inflicting significant but less severe injury and had not been immediately ejected from the premises or arrested, which is the normal accepted practice in such cases. The more severely injured victim thus had a pretty

²²² Insurers can of course be harmed by intermediary error or misconduct. However, as principals with contract relations with the intermediary, an injured insurer will have at least breach of contract remedies and perhaps other avenues of relief as well.

²²³ No. 04-2359-JWL, 2004 U.S. Dist. LEXIS 23726 (D. Kan. Nov. 22, 2004).

²²⁴ 468 F. Supp. 2d 1321 (D. Kan. 2007).

²²⁵ *Id.* at 1323, 1332-33.

²²⁶ *Id.*

good premises liability claim against the bar and consequently sued. The bar nightclub submitted the claim to its insurance agent.²²⁷

Simple case, right? On its face, the matter seemed one to settle for some reasonably serious money fairly quickly so that the plaintiff would not get before a jury that could find him afflicted with seven figures worth of injury (his face had been crushed and had to be extensively rebuilt with metal plates and plaintiff, a school teacher in his thirties, had also suffered significant cognitive injury).²²⁸ But the actions of the first TPA took the case outside the realm of the simple.

The incident and injury took place in April 2000.²²⁹ In Summer 2000, the bar's general liability insurer changed from a Lloyd's group to First Specialty.²³⁰ Plaintiff counsel's February 2001 notice and demand letter did not set forth the date of the incident.²³¹ Suit was filed in October 2001 and the copy passed along was not clear regarding the April date of the incident.²³² The First Specialty TPA (Ward North American) incorrectly assumed that the injury took place in April 2001, during the First Specialty coverage period, rather than April 2000 during the Lloyd's coverage period. The First Specialty TPA (Ward, which subsequently became NovaPro) retained defense counsel, who represented the bar through arbitration, demanding trial de novo after a \$175,000 award.²³³ Finally, in mid-March 2003, the First Specialty TPA discovered the mistake and notified the apt Lloyd's managing general agent (Mavon,

²²⁷ *Id.* at 1332-33 (“no question” plaintiff was “very seriously injured” and that “the \$445,000 settlement ultimately reached was reasonable, that it was the result of good faith negotiations, and that [circumstances of the case] did not . . . result in an ‘over-payment’ to [plaintiff].”).

²²⁸ *Id.*

²²⁹ First Specialty Insurance Corporation, 468 F. Supp. 2d at 1323.

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.* at 1323-24.

²³³ *Id.* at 1324.

which was the Lloyd's independent contractor for claim notice purposes) who in turn alerted the Lloyd's TPA, Elliston.²³⁴

At this juncture, the situation was unfortunate on many levels. The first TPA's error had resulted in the wrong insurer expending defense costs. But the defense to date had been a relatively light one, without substantial attorney time spent fighting the arbitration or conducting discovery.²³⁵

²³⁴ *Id.*

²³⁵ The minimalist nature of the defense provided by First Specialty's chosen counsel became a major issue in the case in that Elliston/Lloyd's took the position that not only was notice of the claim late but that they had been prejudiced by the late notice because the underlying tort claim was so far along and had not been defended with sufficient aggressiveness. This type of late notice/prejudice defense, although a staple of insurance law (and a frequent favorite of insurers looking for reasons not to pay a claim), is a particularly hard one to make in New Jersey. The state's arguably leading case on the matter rejected the defense even though the insurer did not receive notice of the matter until *after* a default judgment had been obtained against the policyholder. *See Morales v. Nat'l Grange Mut. Ins. Co.*, 423 A.2d 325, 327 (1980); *accord Hatco Corp. v. W.R. Grace & Co.*, 801 F. Supp. 1334, 1372-73 (D.N.J. 1992) (six-year delay in notice not sufficient to cause actual prejudice to insurer); *see also Cooper v. GEICO Ins. Co.*, 237 A.2d 870, 873-74 (1968) (adopting appreciable prejudice test and notice-prejudice rule as state law); *see also Molyneaux v. Molyneaux*, 553 A.2d 49, 51 (1989) (reaffirming state law on the point). In one case rather similar to the instant matter where the delay resulted from a misunderstanding that had the wrong insurer initially defending the matter, the late notice defense of the right insurer was rejected due to an absence of prejudice. *See Vornado Inc. v. Liberty Mut. Ins. Co.*, 254 A.2d 325, 328-29 (1969).

Winning a late notice defense in New Jersey is an uphill battle even with compelling facts. Only if the defense lawyer used by First Specialty had done horrendous work (or non-work) was this defense likely to succeed. In reviewing the matter after hearing evidence at trial, the court:

. . . came away from trial with the distinct impression that, at best, Ward did average or "C" work on the [underlying plaintiff's] claim *before* suit was filed. The record is very thin as to whether the way in which the [plaintiff's] claim was handled by Ward was materially better or worse than other claims it was adjusting for First Specialty and other insurers. Nevertheless, *after* suit was filed in October 2001, the record suggests that Ward and [defense attorney Stephen] Wellinghorst together took reasonable actions to investigate and defend the [plaintiff's] claim.

[T]he court formed the impression that Wellinghorst’s skills as a trial lawyer are generally on par to those actually exhibited by the fine lawyers who represented First Specialty, Lloyd’s and Ward in the instant coverage litigation.

The court further finds that Wellinghorst used the above-described skills to do a reasonable and competent job in defending [the policyholder] in a case that presented very few, if any, viable defense opportunities on the primary issues of liability and damages. The court, however, has no illusions that Wellinghorst did an outstanding job, let alone a “perfect” job, with his defense of [the policyholder].

[However,] it was Wellinghorst who discovered Ward’s mistake with regard to the date of loss and policy coverage issue. He could have remained silent upon that discovery in an effort to avoid the instant litigation. But instead he did the right thing by notifying Ward. *See First Specialty v. Novapro*, 468 F. Supp. 2d at 1329-30 (emphasis in original).

With the exception of the statement that Ward “could have remained silent” on the matter, the court’s assessment seems unquestionably correct. I was retained by First Specialty as an expert witness in the case (more on that below) and have reviewed the record in the underlying tort matter as well as the coverage dispute. The court’s assessment of the litigation reality of the matter is close to unassailable. Attorney Wellinghorst and Ward/First Specialty did not mount a scorched earth defense of the barroom brawl claim but did an adequate job. More important, a scorched earth defense would have only needlessly wasted resources and potentially exposed the policyholder to an excess verdict. The case was a strong one for plaintiff, with essentially no question regarding policyholder liability and the essential magnitude of plaintiff’s injuries.

The case didn’t need aggressive defense but instead required aggressive settlement efforts to resolve the matter at a figure that was sufficiently generous to eliminate the claim without overpaying plaintiff. Wellinghorst, Ward, and First Specialty in my view (and the court’s) accomplished this with almost flying colors. A \$435,000 settlement is not necessarily a bargain for the insurer, but is a more than reasonable amount in a case with no good liability defenses and a young plaintiff with substantial medical bills, a year of missed work, permanent brain damage, and permanent facial disfigurement. There was also significant testimony putting this settlement in range of similar cases in the locality in question (Atlantic County and the New Jersey Shore). One need not be a Bon Jovi devotee (the barroom brawl occurred in Sayreville, the singer’s home town) to realize that bodily injury verdicts in a relatively urbanized part of the East Coast are frequently substantial, often reaching seven figures. If the case had been venued in the rural West, Lloyd’s might have had some ground for objecting to the size of the settlement but this argument was in my view unpersuasive as a matter of law in light of the actual trial location and the unquestioned seriousness of the injuries to plaintiff.

But on the issue of attorney Wellinghorst’s obligations, the court’s assessment was hopefully only a rhetorical tangent rather than a serious pronouncement about

Now trial was scheduled for late summer 2003. Elliston complained that it was now too late and that it (and more important) Lloyd's had been prejudiced by the late notice and need not cover the matter even though the claim clearly arose during the Lloyd's coverage period. The argument was astoundingly weak in light of applicable New Jersey law²³⁶ and the

attorney professional responsibility. A defense attorney retained by an insurer or claims intermediary owes a duty of candor to the insurer. Although the rights of the policyholder defendant as primary client of the attorney are greater and take precedence in the event of conflict, the attorney generally has no right to remain silent when it discovers information that may affect the insurer's rights as a party that contracted to provide legal services to the policyholder. In this case, because the policyholder had insurance with Lloyd's during the time of the brawl, there was no policyholder-insurer conflict sufficient to permit defense counsel to withhold from the insurer the important information regarding the actual date of loss. If First Specialty had attempted to use the information to abandon its policyholder on the eve of trial, Attorney Wellinghorst would have presumably advised the insurer of the policyholder's rights and a possible bad faith claim against the insurer. But in my view, Wellinghorst had no discretion to withhold the information from Ward/First Specialty and would have been subject to breach of contract or legal malpractice liability (in states that consider the insurer to be a "client" of the defense attorney) had he done so.

²³⁶ See *supra* note 165. Elliston and Lloyd's also argued, based on New Jersey's "Best Practices" rules, that the time for conducting discovery had passed and that it was now too late to conduct discovery or other litigation activity that could cure the alleged inadequacies of the defense prior to their notification. The "Best Practices" rules set discovery deadlines for particular types of cases but, in practice, appear to be as malleable as any other discovery deadlines. Discovery in the barroom brawl case was "technically set to end on September 10, 2002" months before notification to Elliston/Lloyds but:

[T]he evidence at trial was essentially uncontroverted that the parties continued to conduct discovery through the summer of 2003 [the eve of trial], including depositions of [plaintiff and three other arguably important witnesses]. Despite Lloyd's speculation, there simply is no credible evidence in the record to support the notion that [plaintiff's counsel or the New Jersey trial court] would have sought to strictly enforce Best Practices had Lloyd's decided to become involved in [defense] in the spring and summer of 2003. Nor is there any credible evidence in the record that [plaintiff counsel] or the presiding judge would have moved at trial to strike any discovery taken on behalf of [the defendant policyholder] after the Best Practices discovery deadline."

practical realities of trial in every jurisdiction, where custom and practice as well as the discretion accorded under the rules auger in favor of granting additional discovery or postponement of trial where a party or counsel is brought into a case late in the day.

The Elliston/Lloyd’s complaint about prejudice also appears to have been mere pretext in that Elliston essentially articulated the defense and sat on its hands rather than at least exploring the defense and settlement options. Although Elliston was not in a great position, it made essentially no effort to salvage the situation. It did not seek a postponement of trial. It did not retain counsel or assume control of the case with existing defense counsel. It did not seek to conduct additional investigation or discovery. Most important, Elliston made no effort to assess the liability exposure presented by the case or to settle the matter on reasonable terms.²³⁷

Instead, Elliston and Lloyd’s refused to take over the case, leaving First Specialty holding the metaphorical bag. If First Specialty had stopped defending the bar and trying to settle the case down the home stretch, it would have been vulnerable to serious allegations of bad faith by the policyholder.²³⁸ Making what it thought was the best of a bad situation,

See First Specialty v. Novapro, 468 F.Supp.2d at 1332. Because it is the insurer’s burden to show prejudice from late notice, the absence of this evidence prior to trial would logically have supported summary judgment for First Specialty on this issue. Merely by permitting trial on this point, the court arguably did Elliston/Lloyd’s a favor and gave the “discovery deadline has passed” defense more regard than it deserved.

²³⁷ *See Id.* at 1335:

Clearly, Lloyd’s was placed in a less than ideal position by the late notice of the Femia claim. The evidence at trial, however, simply does not support the assertion that Lloyd’s irretrievably lost substantial rights as a result of late notice of the [barroom brawl] claim. Indeed, the evidence strongly suggests that, had Elliston *actively* intervened in March 2003, and it definitely could have done so under a reservation of rights, it still would have been able to investigate, defend, and/or settle the [underlying] case without significant impediment.

Id.

²³⁸ *See id.* at 1339 (First Specialty “was essentially ‘stuck between a rock and a hard place’” because of duties to policyholder, even if claim did not fall within First Specialty policy period). *See, e.g., Griggs v. Bertram*, 443 A.2d 163, 167

First Specialty conducted additional discovery and analysis (making up in significant degree for the admittedly minimalist defense it had conducted prior to that time) and settled the case in a range deemed appropriate by seasoned counsel and ultimately by the court in the ensuing litigation wrought by the mistakes of the two claims intermediaries (Ward and Elliston).²³⁹

An old adage of the radio business is that “if you don’t have time to do it right the first time, you’ll never have time to fix it.” Although not literally true, the saying, like the better known “stitch in time saves nine” nicely captures the higher remedial cost that is created by errors at the outset. If Ward had correctly realized that the incident was not within the First Specialty coverage period, the claim would have gone to Elliston and Lloyd’s, who could have defended and settled (or not settled) the case as seen fit. Instead, the matter went from largely simple and routine to more complex and unusual. Having paid \$445,000 to settle the bodily injury claim plus defense costs, First Specialty wanted reimbursement from the insurer that should have handled the claim from the outset.²⁴⁰

Although Elliston’s errors as the Lloyd’s intermediary are less obviously fumbling than those of Ward, they were significant. Although Elliston (and Lloyd’s) received notice later than desired, there was still a significant amount of time to take over the case and defend or settle it to its liking rather than whining that it was stuck with the alleged claims handling errors of First Specialty and defense counsel. Instead of acting reasonably, Elliston postured. For example, it claimed that further discovery was unavailable due to the close of the discovery period without even trying to obtain a reopening or an agreement with opposing counsel to conduct depositions, physical examinations, or the like. As nearly every litigator knows, most anything can be done by agreement of counsel, which is not normally unreasonably withheld because courts are generally empowered to grant these extensions and exceptions unless the matter is one of the few “jurisdictional” deadlines over which courts have no discretion.

(1982) (carrier beginning defense without reservation of rights estopped from denying coverage). Because of the error of its TPA, First Specialty understandably viewed the claim as falling clearly within its coverage and did not defend under a reservation of rights.

²³⁹ See *First Specialty v. Novapro*, 468 F. Supp. 2d at 1338-41.

²⁴⁰ See *id.* at 1323-25 (describing background of litigation).

Elliston's intransigence could have been simple laziness or negligence. It could also have been (and in my view was) tactical posturing designed to keep First Specialty “stuck” with the coverage obligation that rightfully belonged to Lloyd's and for which Lloyd's (not First Specialty) had received a premium. It is more than possible that Elliston was not dropping the claims handling handoff because of incompetence or sloth but because it was doing the bidding of Lloyd's in trying to paint First Specialty into a corner from which it could not escape through using the pretextual excuse that it was now “too late” for Elliston to pick up the claim and that Lloyd's was prejudiced in its ability to defend and cover the matter.

All of this brought about an additional lawsuit by First Specialty seeking reimbursement from Lloyd's based on subrogation and unjust enrichment. First Specialty also sued its TPA (which had blown it so badly on the actual date of the plaintiff's injury at the bar) and sued Elliston as well as Lloyd's. An unfortunate but hardly remarkable barroom assault that probably should have resulted in no significant litigation became a battle royal that resulted in a second lawsuit (in addition to the injured patron's bodily injury/inadequate security claim), extensive pretrial discovery, retention of experts,²⁴¹ four pretrial judicial opinions²⁴² a week-

²⁴¹ See *id.* at 1336-37 (in which the court makes “specific credibility findings” about various witnesses, including expert witnesses, even though the decision was not, according to the court, based on any expert testimony). As noted above, I was retained as an expert for First Specialty, as was former U.S. District Court Judge Curtis Meanor of the District of New Jersey. Lloyd's retained George Kenney, a prominent practitioner and co-author of New Jersey Insurance law. See GEORGE KENNY & FRANK A. LATTEL, NEW JERSEY INSURANCE LAW (2d ed. 1993).

²⁴² See *First Specialty Ins. Corp. v. Ward North America Holdings, Inc.*, 2004 WL 2672833, at *1 (D. Kan. Nov. 22, 2004) (denying Lloyd's motion for change of venue to New Jersey); *First Specialty Ins. Corp. v. Novapro Risk Solutions, LP*, 468 F. Supp.2d 1321, 1336-37 (D. Kan. 2007) (referring to earlier pretrial ruling rejecting *Daubert* challenge to proffered expert that resulted in written opinion not available in LexisNexis database); see also *First Specialty Ins. Corp. v. Ward North America Holdings, Inc.*, 2005 U.S. Dist. LEXIS 33250, at *3 (D. Kan. Dec. 15, 2005) (denying St. Paul Travelers motion to dismiss without prejudice on technical grounds that submission of affidavit converted it to summary judgment motion that was premature); *First Specialty Ins. Corp. v. Ward North America Holdings, Inc.*, 2005 WL 3447708, at *1 (D. Kan. Dec. 15, 2005) (granting Elliston's motion to dismiss) (all opinions by District Judge John W. Lungstrum); *First Specialty Ins. Corp. v. Ward North America Holdings, Inc.* 2006 U.S. Dist.

long trial and a 20-page bench opinion.²⁴³ The collective expense of the enterprise was hundreds of thousands spent on out-of-pocket disputing costs and at least tens of thousands of dollars worth of judicial resources (by three different judges and their staffs) shouldered by taxpayers even if not formally billed in itemized fashion.

And who paid for this train wreck? The claims intermediaries who caused and exacerbated it? Hardly. In its findings of fact and conclusions of law, the court found that Ward (First Specialty's administrator) could not be liable in negligence unless there was a finding of prejudice to either insurer as a result of late notice. Finding no prejudice, the court granted Ward's motion for judgment as a matter of law.²⁴⁴ Elliston (the Lloyd's administrator) did even better in that it was dismissed from the case a year earlier when the court, following the traditional rule on intermediary liability, ruled that First Specialty had no claim against Elliston because there was no contract between First Specialty and Elliston.²⁴⁵

LEXIS 60219 (D. Kan., Aug. 22, 2006) (issuing protective order) (by Magistrate Judge Keith G. Sebelius). There were also judicial rulings that are not generally available on online.

²⁴³ See generally *First Specialty v. Novapro*, 468 F. Supp. 2d 1321 (discussing findings of fact and conclusions of law by Magistrate Judge James P. O'Hara).

²⁴⁴ See *id.* at 1343.

²⁴⁵ See *First Specialty v. Ward*, 2005 WL 3447708, at *1-2 (Kan. Dec. 15, 2005) ("First Specialty asserts the breach of the duty of good faith and fair dealing against Elliston without asserting any contractual relationship with Elliston. The claim for bad faith in denying an insurance claim 'is best understood as one that sounds in contract.'") (citing Kansas precedent and *Charleston Dry Cleaners & Laundry, Inc. v. Zurich American Ins. Co.*, 586 S.E.2d 586, 588 (S.C. 2003) which was discussed *supra* notes 102-103 and accompanying text) (citation omitted); see also *Wolverton v. Bullock*, 35 F. Supp. 2d 1278, 1280-81 (D. Kan. 1998). The *First Specialty* Court echoed the *Charleston Dry Cleaners* sentiment that the "duty of good faith arising under the contract does not extend to a person who is not a party to the insurance contract. Thus, no bad faith claim can be brought against an independent adjuster or independent adjusting company." See *First Specialty v. Ward*, 2005 LEXIS 33247 at *2, quoting *Charleston Dry Cleaners*.

In addition, the court rejected the claim that there was any special relationship with Elliston that would support a breach of fiduciary duty claim. See *id.* at *7 ("First Specialty is not the insured in this case, and even more damaging to its claim, Elliston is not the insurer. The parties are completely attenuated, and

At the end of this litigation day, then, two entities substantially responsible for a lot of wasted time, energy and money escaped liability, at least judicially imposed liability. At a minimum, this seems inconsistent with the basic notion that a rational legal system should create sufficient incentives for adequate care and hold persons and entities accountable when their errors cause injury to others who might reasonably foreseeably suffer such injury.

One response to this concern and to my criticism of intermediary immunity to third parties is that the parties who do have contractual relations with the intermediaries will have a cause of action against the errant intermediary, thus providing adequate deterrence and compensation even though the third party will not be the instrument of that deterrence and compensation. But cases like *First Specialty* refute this contention on both legal and practical grounds.

First the legal grounds. The federal trial court ruled that Ward, the administrator that was too dense to realize that it had improperly saddled its principal with coverage responsibilities, was not liable to the principal because the principal was ultimately able to get reimbursed for most of the

accordingly, First Specialty cannot assert any breach of fiduciary duty. Like the claim for good faith and fair dealing, the claim for breach of a fiduciary entirely turns upon a contract between the parties.” With no contract, First Specialty has no claim.”) (citation omitted). The court’s conclusion that the parties are “completely attenuated” is wrong. They may not have been contractually linked, but there are only a couple degrees of separation between them. Complete attenuation implies no logical ties whatsoever. On the contrary, it is more than a little likely and foreseeable that two insurers and their intermediaries might become involved in a claim against their common policyholder. For example, if the barroom brawl had happened at midnight on the day on which the policy periods changes, these parties could have been in dispute as to coverage and claims handling obligations even without any misfeasance by either claims administrator.

With the benefit of 20-20 hindsight, one might also chide First Specialty counsel for not formally making a negligence claim against Elliston, the theory being that although Elliston might not be a “fiduciary” to First Specialty in light of its greater loyalty to (and contract with) Lloyd’s, Elliston at least had basic tort-like duties to First Specialty and others reasonably foreseen as affected by its handling of the claim. Elliston was actually and constructively aware that by failing to pick up the defense and handling of the barroom brawl claim it was putting First Specialty in a position where it had to protect the Lloyd’s policyholder even though the loss was not the contractual responsibility of First Specialty and that this would impose considerable costs on First Specialty, costs that could only be recouped if First Specialty assumed the burden of settlement.

costs by Lloyd's once it was found that Lloyd's was not prejudiced by the delay in receiving notice of the matter. First Specialty "conceded" this "during trial," which may have been good judicial politics in that it made the insurer look less greedy and reduced the adjudicative burden on the court. But was it right under the law – and should the court have accepted this concession even in an adversary system where parties are largely free to drop claims for any reason?

Although First Specialty essentially gave up on its negligence claim against Ward by taking the position that it was fully compensated if it could prevail against Lloyd's, First Specialty's legal generosity and the court's summary disposition of the negligence claim is not very persuasive. Without doubt, Ward was negligent and negligence of this type also breach of contract as well as inflicting reasonably foreseeable injury upon an entity to which Ward owed clear duties of care and minimal competence. Ward's negligence and breach of contract entitled First Specialty to relief and payment of apt damages.

Even if a successful action against Lloyd's largely made First Specialty whole, there undoubtedly was lost time and productivity inflicted on First Specialty because of the Ward's error. Logically, at least some of this injury remained uncompensated from the judgment against Lloyd's. If nothing else, it appears from the court's judgment that First Specialty shouldered all of its counsel fees in prosecuting its subrogation and unjust enrichment claim. At the end of the day, then, we see a situation in which even the principal of an insurance intermediary is not getting relief against the intermediary even in a case of egregious error.

Now, the practical grounds. The other intermediary, Elliston, of course was in a contract relationship with its principal, Lloyd's. The errors of Elliston arguably inflicted injury upon Lloyd's, unless Lloyd's was calling all shots regarding the barroom brawl claim and therefore removing any discretion. If Lloyd's was calling the shots, presumably there was no breach of contract by Elliston. But such a situation illustrates the unwisdom of the traditional rule. If Elliston were subject to a liability claim by First Specialty, it logically would have made Elliston think twice about blindly taking orders from its principal to do nothing to salvage the claims handling situation when it received notice of the problem.

An intermediary facing potential tort liability is more likely to exercise independent judgment that might save all concerned needless injury, aggravation, and litigation. If instead the poor decision to refuse to take over the claim was really Elliston's decision, it proved a costly one to Lloyd's. Under the theory underlying the majority rule protecting intermediaries from liability to third parties, one would expect the principal

to sue the errant intermediary. However, it appears that Lloyd's has made no such claim against Elliston.

After the dust of the *First Specialty* litigation settled, it appears that neither intermediary (Ward nor Elliston) was forced to accept responsibility for pretty poor performance of its duties to its principals and the duties I argue they have to third parties. In this case, it is hard to get too emotional about the result. First Specialty is a commercial entity of some wealth that could have survived even it had not been able to recover against Lloyd's. Having recovered, it was not greatly harmed by the errors of Ward and Elliston even though it in my view was far from made whole. Likewise, Lloyd's syndicates are unlikely to suffer substantial injury due to isolated errors in claims adjustment or litigation.

More disturbing is the prospect that the errors of the intermediaries could have resulted in substantial harm to the policyholder or the claimant in situations like this. For example, the late notice and Elliston's refusal to accept responsibility (and the manner in which the intermediary errors shaped insurer positions) could have created a situation in which the policyholder was left without a defense or subject to a judgment in excess of the policy limits. The claimant could have been put in a situation requiring years of litigation simply to get compensation for what were undeniably serious injuries resulting from pretty clear policyholder negligence that was subject to liability insurance coverage. None of these are good possibilities. Fortunately, the worse was averted in spite of the unreasonable legal deference accorded to claims intermediaries who turned in very defective performances of their basic tasks. The *First Specialty* litigation, however intellectually interesting, was a huge waste of resources largely due to intermediary error. This hardly provides a persuasive brief for clinging to the historical rule of intermediary immunity.

Reviewing the *First Specialty* wreckage, one might recall the public policy argument made in favor of the general rule (most prominently in cases like *Sanchez*, *Meineke* and *Hamill*)²⁴⁶ positing that imposing liability on intermediaries would be bad because it would move more of the claims function back in house to the insurers or raise prices for basic adjusting services. To that argument, I ask why this would be a problem. In-house claims adjusters surely could not have done worse than Ward and Elliston. And if the specter of liability results in an increase in adjuster fees, this might be a penny well paid to reduce the pound-foolishness of independent contractor intermediaries who cannot even put a loss in the

²⁴⁶ See *supra* notes 101-141 and accompanying text.

right policy period and that are unable to pick up defense and settlement of a straight-forward assault case months before trial. Although the cases are not legion and the problem is hardly law's most pressing, one cannot help but wonder why the judiciary strains so hard to protect claims intermediaries under these circumstances.

IV. THE ANALYTICAL AND PRACTICAL ADVANTAGES OF REMOVING BLANKET IMMUNITY FOR CLAIMS INTERMEDIARIES

A. REVISITING DOCTRINE: THE AGENT AS TORTFEASOR

The privity and disclosed principals doctrines, despite their historical pedigree, have always rested on a relatively weak foundation. The notion that a contractual relationship is required to grant one rights vis-à-vis other social actors was never as broad or absolute as its defenders maintained. Even in the absence of contract, social actors have certain social responsibilities if placed in situations where their behavior can cause harm to others. The legal system acknowledges this, of course, through a vast body of tort law in which actors are held to have duties toward others, often even total strangers. Seen in this light, one can argue that the old-fashioned citadel of privity, which most famously collapsed in product liability law,²⁴⁷ was always overreaching in its quest to immunize defendants and limit the reach of tort law. Many of the traditional lack-of-privity decisions tacitly but mistakenly assumed that there were no rights at all in the absence of formal contract rights. These courts simply acted as if tort law rights were beyond realistic consideration.²⁴⁸ As again revealed most clearly in the product liability context, there were always strong reasons to impose tort liability upon certain conduct with a sufficiently close connection to foreseeable injury to certain parties once it was recognized that the absence of a contract was not disqualifying.

²⁴⁷ See *supra* notes 9-12 and accompanying text (discussing *MacPherson v. Buick* and fall of the citadel of privity in product liability matters).

²⁴⁸ See *supra* notes 101-141 and accompanying text (citing cases immunizing intermediaries on lack-of-privity grounds, expressly or implicitly finding that without contract-based rights, third parties had no legal liability rights against intermediaries).

In effect, courts were mixing apples and oranges by concluding that the mere absence of a contract precluded legal relief on other grounds. Often they were aided and abetted by plaintiffs' counsel who, perhaps having stars in their eyes about potential punitive damages awards, bet all their litigation chips on seeking to make bad faith claims against intermediaries and overlooked the compelling logic of holding a claims adjuster accountable in tort, as would be a passing driver or machinery operator.

Applied to claims intermediaries, the logic of tort law unfettered from a contract-based limitation is compelling. The very nature of the claims process and the intermediaries' role should be recognized as creating at least some duties of at least modest care toward claimants and policyholders. Both are in a vulnerable position relative to the insurer and adjuster. Failure of the adjuster to act in an honest, fair, objectively reasonable manner is almost certain to cause at least some harm in the disposition of the claim.

In some instances, the harm will only be the relatively minor problem of delay or perhaps some quibbling over relatively small amounts of money, insistence on nit-picking documentation, or similar wrongs, that despite resulting from adjuster misconduct, are unlikely to result in litigation. But in other instances, adjuster error can result in substantial delay, dramatic underpayment, or outright denial – all of which may impose not only ordinary breach-of-contract type harms but may also give rise to substantial consequential damages, perhaps even significant physical and mental injury to policyholders or others. In these latter types of cases, there is no reason not to hold claims intermediaries accountable for their actions.

In addition, the traditional agent immunity rule in disclosed principal cases has always been in some tension not only with basic tort law concepts (and jurisprudential or philosophical notions of justice, responsibility and accountability) but also with other aspects of agency law. For example, even agents for disclosed principals may be liable to those with whom they negotiate if they have misled the third party as to the agent's authority.²⁴⁹ Although this traditional form of agent liability is premised more on contract grounds (i.e., the agent misrepresenting his

²⁴⁹ See HAROLD GILL REUSCHLEIN & WILLIAM A. GREGORY, *THE LAW OF AGENCY AND PARTNERSHIP* §§ 119-121 (2d edition); *see, e.g.*, *Schafer v. Fraser*, 290 P.2d 190 (1955).

authority has induced reasonable reliance that causes detriment to the third party), it nonetheless provides strong historical support for the proposition that where agents take volitional acts that cause injury to third parties, liability is appropriate.²⁵⁰

In addition, notwithstanding the protection historically bestowed by the disclosed principal rule, “[a]n innocent agent who is responding to the orders of a principal may be liable without fault for torts such as trespass to land, conversion and defamation.”²⁵¹ In addition,

[f]or other torts the agent is liable only if it proved that he possessed the requisite state of mind. Illustrative of such torts are deceit, malicious prosecution, interference with business and negligence. Under no circumstances, except where he is acting to protect an interest of the principal, is the fact that the agent is acting within the scope of employment or the command of the principal a defense. . . . [T]he liabilities of the agent may be increased simply because he has asserted control over the property or other agents of his principal or because he has presumed to do something which, if properly accomplished, would have prevented harm to others.²⁵²

²⁵⁰ And in misrepresentation of authority cases, the damages can be significant. *See id.* at § 120 (damages may include net value of transaction that would have taken place if authority had been represented, plus counsel fees)(citing cases from the 1950s). *See also id.* § 125 (“mere fact that an agent acts on account of his principal does not exonerate him of liability for misrepresentations he makes to a third party).

²⁵¹ *See* REUSCHLEIN & GREGORY, *supra* note 249, at § 124 (citations, including two cases from the 19th Century, omitted).

²⁵² *See* REUSCHLEIN & GREGORY, *supra* note 249, at § 124 (citations omitted). *See also* *Leathers v. Aetna Cas. & Sur. Co.*, 500 So. 2d 451, 453 (Miss. 1986)(“[O]ur general rule in tort is that the agent or servant, the one whose conduct has rendered his principal liable, [also] has individual liability to the plaintiff.”); *see generally* WARREN SEAVEY, *STUDIES IN AGENCY* 1 (1949); *see generally* Warren Seavey, *Liability of an Agent in Tort*, 1 SOUTHERN L.Q. 16 (1916).

Most important for purposes of assessing claims adjuster exposure, “[t]he fact that one acts as an agent does not absolve him from liability for his negligence.”²⁵³

Particularly relevant is that “[s]ome jurisdictions will hold the agent liable if the agent has undertaken the sole and complete control and management of the principal’s premises. In such circumstances, the agent’s omission is an act of misfeasance, rather than mere nonfeasance” although “the agent is not liable for the negligence of the principal” in the absence of the agent’s own negligence.²⁵⁴

As noted above, in modern claims adjusting, insurers frequently have essentially given independent contractor adjusters and MGAs something quite close to “sole and complete control and management” of the claims process and other aspects of the insurer-policyholder relationship. Applying this general maxim of agency from the *Restatement (Second)* rather than the disclosed principal immunity of *Restatement (Second)* § 320, logically would require that claims intermediaries be held accountable for their negligence to apt third parties without reference to whether the third party enjoys a contractual relationship with the intermediary. Other sections of the *Restatement (Second)* all are quite supportive of agent liability under apt circumstances.²⁵⁵

²⁵³ See REUSCHLEIN & GREGORY, *supra* note 249, § 128 at 203 (citing ALI RESTATEMENT (SECOND) OF AGENCY §348A). The citation to § 348A seems a bit off here in that this section specifically addresses “Trespass to Land” rather than general negligence. However, other portions of the *Restatement (Second)*, particularly § 343, support this view. See RESTATEMENT (SECOND) OF AGENCY §348-§348A.

²⁵⁴ See REUSCHLEIN & GREGORY, *supra* note 179, § 128, at 203 (citing *Paul v. Sharpe*, 181 Ga. App. 443, 352 S.E.2d 626, 629 (1987) and *Robinson v. Allstate Ins. Co.*, 399 So. 2d 288, 290 (Ala. 1981)).

²⁵⁵ See, e.g., RESTATEMENT (SECOND) AGENCY § 343 (1958):

An agent who does an act otherwise a tort is not relieved from liability by the fact that he acted at the command of the principal or on account of the principal, except where he is exercising a privilege of the principal, or a privilege held by him for the protection of the principal’s interests, or where the principal owes no duty or less than the normal duty of care to the person harmed.

Restatement (Second) Agency § 350 (1958):

An agent is subject to liability if, by his acts, he creates an unreasonable risk of harm to the interests of others protected against negligent invasion.

Restatement (Second) Agency § 344 (1958):

An agent is subject to liability, as he would be for his own personal conduct, for the consequences of another's conduct which results from his directions if, with knowledge of the circumstances, he intends the conduct, or its consequences, except where the agent or the one acting has a privilege or immunity not available to the other.

Restatement (Second) Agency § 347 (1958):

(1) An agent does not have the immunities of his principal although acting at the direction of the principal.

(2) Where, because of his relation to a third person, a master owes no duty, or a diminished duty, of care, a servant in the performance of his master's work owes no greater duty, unless there has been reliance by the master or by a third person upon a greater undertaking by the servant.

Restatement (Second) Agency § 348 (1958):

An agent who fraudulently makes representations, uses duress, or knowingly assists in the commission of tortious fraud or duress by his principal or by others is subject to liability in tort to the injured person although the fraud or duress occurs in a transaction on behalf of the principal.

Restatement (Second) Agency § 348A (1958):

An agent who enters the land of another is not relieved from liability for trespass by the fact that he acted on account of the principal and reasonably believed that the principal had possession or the right to possession of the land, or the right to authorize the agent to enter.

Restatement (Second) Agency § 349 (1958):

An agent who does acts which would otherwise constitute trespass to or conversion of a chattel is not relieved from liability by the fact that he acts on account of his principal and reasonably, although mistakenly, believes that the principal is entitled to possession of the chattels.

Restatement (Second) Agency § 351 (1958):

The *Restatement (Third)* continues in this vein, providing a general rule that

[a]n agent is subject to liability to a third party harmed by the agent’s tortious conduct. Unless an applicable statute provides otherwise, an actor remains subject to liability although the actor acts as an agent or an employee, with actual or apparent authority, or within the scope of employment.²⁵⁶

Although this leaves for resolution the sometimes difficult question of whether an agent’s conduct is “tortious” in that it negligently, recklessly, or intentionally violated a duty,²⁵⁷ the modern “hornbook rule” of the

An agent who directs or permits conduct of another under such circumstances that he should realize that there is an unreasonable risk of physical harm to others or to their belongings is subject to liability for harm resulting from a risk which his direction or permission creates.

²⁵⁶ See, e.g., RESTATEMENT (THIRD) AGENCY § 7.01 (2006). Reporter’s Note (a) to § 7.01 specifically notes that the section “consolidates treatment of points made by” the RESTATEMENT (SECOND) AGENCY “in several sections, including §§ 217, 343, 344, 345, 346, 347, 348, 349, 350, 351, 358 and 360.” *Accord*, *Oriental Trading Co. v. Firetti*, 236 F.3d 938, 945 (8th Cir. 2001) (applying Nebraska law and finding individual corporate officers personally liable for fraud and misrepresentation even though working for corporate entity as principal); *Inter-Connect, Inc. v. Gross*, 644 So. 2d 867, 869 (Ala. 1994) (holding the president of the company individually liable for wrongful actions taken in individual capacity); *T.V. Spano Bldg. Corp. v. Dept. of Natural Res.*, 628 A.2d 53, 62 (Del. 1993) (finding the corporate officer is not immune from an action seeking personal liability for his role in corporate pollution).

²⁵⁷ See RESTATEMENT (THIRD) AGENCY § 7.02 (2006) (“agent is subject to tort liability to a third party harmed by the agent’s conduct only when the agent’s conduct breaches a duty that the agent owes to the third party”). See also RESTATEMENT (THIRD) AGENCY § 7.02 cmt. d at 141 (2006):

Conduct by an agent that breaches a duty owed by the agent to the principal does not subject the agent to liability to a third party who suffers pure economic loss as a result unless the agent’s conduct also breaches a duty owed by the agent to the third party. Most cases hold

Restatement is hardly one of automatic immunity for agent misconduct simply because the agent and the third party have not entered into a contract.

The differing strands of hornbook agency law can be reconciled by appreciating that the disclosed principal immunity accorded agents pursuant to § 320 is purely an immunity from being held liable under contract. Section 320 (and its modern equivalent § 6.01 of the *Third Restatement*) provide only that an agent for a disclosed principal “does not become a party to the contract” because of agent status. By expanding this presumptive contract claim immunity into a general immunity from suit by third parties, courts immunizing claims adjusters have engaged in quite a bit of judicial activism in favor of this class of defendants.

The absence of a contract and contract claim hardly ends the inquiry. Actors such as claims intermediaries can still logically be liable in tort. Traditional rule courts have either tended to ignore this or quickly leap to the conclusion that the nature of the claims management process does not create a tort duty of reasonable care toward the policyholder or liability claimant.²⁵⁸

This view is wrongheaded for reasons already discussed. The adjuster plays the role of an insurer. Insurers owe a fiduciary duty to policyholders defending liability claims and a near-fiduciary duty to first-party policyholders as well as having more limited duties to third party claimants. By analogy, the claims intermediary ceded substantial authority by the insurer logically owes similar duties.²⁵⁹

that an agent does not owe a duty to a third party when the agent’s negligent conduct causes only pure economic loss to a third party.

²⁵⁸ See cases cited *supra* note 21; see also cases cited *supra* notes 101-121. See, e.g., *Badners v. Prudential Life Ins. Co.*, 567 So.2d 1242, 1244 (Ala. 1999); *Gorab v. Equity Gen. Agents, Inc.*, 661 P.2d 1196, 1198 (Colo. App. 1983), *overruled by* *Cary v. United of Omaha Life Ins. Co.*, 68 P.3d 462 (Colo. 2003).

²⁵⁹ At this point in the development of insurance law, insurers no longer contest that they owe duties of good faith to policyholders; however, they often argue against having a full-fledged fiduciary duty, even in liability insurance cases. Although most insurers and counsel are likely to also argue that claims intermediaries are mere agents and do not stand in the insurers’ shoes as alter egos, at least one commentator appears to accept the proposition that where an intermediary is sufficiently like an insurer or performing functions of an insurer, liability should attach. See *Federal Court Predicts Rhode Island Supreme Court*

Even without putting the intermediary in the shoes of the insurer, the very nature of the relationship is one creating a duty of reasonable care and basic honesty and competence. The intermediary is aware of the policyholder or third party’s dependency upon the adjuster and it is reasonable foreseeable that intermediary negligence or other misconduct could cause significant injury.

Under these typical circumstances of claims intermediary activity occurring every day in the field, the standard test for imposing tort liability is clearly met. Section 320’s general prohibition on imposing a contract relationship where the agent represents a disclosed principal hardly negates this basis tort analysis.

Properly understood, then, traditional agency law does not foreclose liability for claims intermediaries and certainly does not grant them broad immunity for their negligence or greater misconduct toward policyholders and third parties.

In addition, adverting again to contract law for a moment, the traditional contract claim immunity and lack of privity defense made by intermediaries arguably conflicts with the modern view of the rights of third party beneficiaries. Historically, contract law was reluctant to recognize a claim for breach by one who was not a party to the contract breached. However, even in the 19th Century, third parties might have rights under a contract if they were sufficiently within the contemplation of the contracting parties or at least intended to benefit from the contract. By the 21st Century, this historical view has expanded somewhat, with courts more often characterizing a contract claimant as an “intended” beneficiary with rights rather than an “incidental” beneficiary with no rights.²⁶⁰

Will Permit Policyholder to Sue Independent Claims Administrators for Common Law Bad Faith in Limited Circumstances, INS. LITIG. REP., Feb. 15, 2007, at 149-150 (supporting general rule in cases of mere intermediary agency but conceding that “[a]rguably, principles of joint venture provide a more theoretically sound basis for imposing liability on a claims adjuster who shares economic risk with the insurer and has significant control over the claims-handling process” and citing the “joint venture” liability cases of *Wohlers v. Bartgis* and *Farr v. Transamerica Occidental Life Ins. Co.*, *supra* notes 92-97). My proposed liability for claims intermediaries is only a modest extension of this concept in that it dispenses with the requirement that there be an economic risk partnership between insurer and adjuster. Under my view, it should be sufficient if the intermediary has significant control over the claims process.

²⁶⁰ See EPSTEIN, MARKELL & PONOROFF, *supra* note 126, at 917-18; FARNSWORTH, *supra* note 10, §§ 10.2- 10.3; see generally Anthony Jon Waters,

The insurance intermediary situation is one in which it clearly appears that both insurer and TPA or adjuster are aware of the position and rights of a policyholder or claimant and where the insurer's contractual retention of an independent contractor to process a claim is intended to benefit the third party. If not, the insurer hiring the intermediary would appear to be in at least technical bad faith in that it has failed to give the policyholder's interests (in getting a fair and swift adjustment of the claim) as much consideration as it has given its own interests (in processing the claim in a swift manner the minimized payouts by the insurer).

B. PRACTICAL CONSIDERATIONS: THE BENEFITS OF POTENTIAL LIABILITY FOR CLAIMS INTERMEDIARIES

Because lack of contract privity and agency law do not compel immunity for claims intermediaries, the question of intermediary liability is best answered through a functional analysis of the relative net benefits of permitting suits against such intermediaries. In contrast to majority rule courts such as *Sanchez v. Lindsey Morden Claims Services, Inc.*,²⁶¹ my application of instrumental, public policy concerns leads to a view that immunity for claims intermediaries is clearly unwise and that at least in some instances, these intermediaries should be subject to liability.

As outlined above in discussing *Sanchez* and similar cases, the public policy arguments mustered in defense of the traditional rule are weak. The claim that insurance intermediaries should be immune from tort liability because they lack the protection of contractually set limits on liability²⁶² is particularly bizarre. By this reasoning, one might just as well conclude that there should be no tort liability for negligent driving since the unfortunate auto accident defendant never had the opportunity to negotiate with his victim about perhaps agreeing to a lower limit on liability.

The Property in the Promise: A Study of the Third Party Beneficiary Rule, 98 HARV. L. REV. 1109 (1985).

²⁶¹ 84 Cal. Rptr. 2d 799 (1999), *see supra* notes 122-149 and accompanying text.

²⁶² *See supra* notes 49-141 and accompanying text (discussing this rationale, as most prominently advanced in *Sanchez* and *Hamill v. Pawtucket Mut. Ins. Co.*, 892 A.2d 226 (Vt. 2005)). *See also* *Meineke v. GAB Bus. Servs., Inc.*, 991 P.2d 267, 270 (Ariz. Ct. App. 1999); *King v. Nat'l Sec. Fire & Cas. Co.* 656 So. 2d 1338, 1339 (Fla. Ct. App. 1995).

Similarly, if one accepts this rationale for tort immunity, one might even prohibit a tort claim against a mugger, unless perhaps the mugger had an adequate opportunity to negotiate a contractual limit on his liability for assault and battery.

This simple illustration not only underscores the common sense absurdity of this attempted justification for claims adjuster immunity but also raise a question of legal doctrine. What on earth is the consideration that would support a bargain in which a victim agrees to limit its right of recovery against (in ascending order of blameworthiness) an errant driver, a sloppy adjuster, or a mugger? None comes readily to mind, suggesting that this attempt to turn lack of contract privity into not only a shield but a sword fails as anything but alchemy via ipse dixit.

As discussed above, the notion that an insurer limits its tort liability by contract is itself incorrect. The policy limits of an insurance policy are a contract-based limitation on a particular type of contract damages, but they hardly constitute the cap of an insurer’s potential liability. As a matter of contract, most liability policies provide a “defense outside of limits” to the policyholder, which means that the insurer is responsible for paying reasonable counsel fees and other defense costs until policy limits are exhausted. In a sufficiently involved case implicating a policy with high limits, defense costs can be millions or even tens of millions of dollars for which there is no documented cap. The insurer’s good faith duties bar it from hurrying to exhaust policy limits simply as a means of lowering its defense expenditures.²⁶³ Beyond this, an insurer that acts in bad faith is, in most states, also subject to consequential contract damages that are not confined to the policy limits as well as being subject to tort damages, including noneconomic damages such as intentional infliction of emotional distress and the possibility of punitive damages.

Similarly, the defense of the historical rule premised on a need to tamp down the costs of claims adjustment and insurance premiums is similarly flawed, both as to fact and public policy. We simply do not know whether forcing adjusters to internalize at least some of the external costs of their errors would inevitably lead to price increases. Economic theory may predict this but countervailing theory predicts that the effect would be minimal or even overshadowed altogether by market conditions and the degree of competition for claims intermediary work or insurance sales.

A strong case can be made that imposing liability for misconduct is not likely to have a great impact on insurance prices unless misconduct is

²⁶³ See STEMPER, *supra* note 27, at § 10.03.

rampant. If not, there will only be a few cases even brought, with fewer cases still resulting in judgments against intermediaries. After judgment, the amount may or may not be enough to prompt a recouping price increase. In some instances, the intermediary may not be able to increase prices and will simply need to absorb the loss and lower profits. In the absence of compelling proof that making claims intermediaries subject to the tort system would bring substantial economic net costs, the judicial system would be wise to stick to doctrine rather than implicitly legislating immunity on speculative grounds. Applying traditional doctrinal analysis, a claims intermediary seems at least as likely a candidate for a negligence action as does an errant driver, restaurant owner, or shopping center.

In addition, the “prices will rise” rationale for limiting intermediary liability, whatever empirical truth it might have, lacks persuasive force as a public policy proposition. It assumes without discussion that an aggregate increase in adjusting costs or insurance costs is bad. That hardly follows. Rather, the question is whether an increase in adjusting costs is outweighed by the benefits of forcing adjusters to act with greater care, providing an alternative source of recovery for victims of bad adjusting, and the moral accomplishment of holding business and social actors responsible for wrongful conduct.

Depending on the amount and magnitude of intermediary misconduct, resulting liability, and aggregate price increases, reasonable minds might differ over the cost-benefit analysis. But the majority rule cases barely acknowledge this tension and fail to grapple with it. A better approach would be to resolve doubts in favor of traditional tort law principles – which argue strongly for permitting actions against errant adjusters – and leave any construction of liability based on policy concerns to legislative actors.

Commercial entities such as MGAs and independent adjusters generally have significantly more clout with state legislatures than do policyholders or consumers in general. If there is a good cost-benefit case to be made against intermediary liability, it will be persuasively made by the intermediaries and their political allies. Until that happens, the judiciary would be more consistent with overarching principles of law (primarily agency and tort law) by permitting liability rather than granting immunity to entities that are well-equipped to seek it in the political process.

Particularly in the context of insurance, a field in which both judicial common law and executive/legislative regulation has identified a need to protect vulnerable consumers, it seems most odd to deny to consumers even the possibility of seeking recompense if they are injured by

the wrongful activities of a claims intermediary. Many majority rule states precluding actions against claims intermediaries justify this on the ground that the plaintiff third party or policyholder can obtain satisfaction from the insurer-principal of the offending intermediary.²⁶⁴ However, as well put by the American Law Institute:

It is consistent with encouraging responsible conduct by individuals to impose individual liability on an agent for the agent's torts although the agent's conduct may also subject the principal to liability. Moreover, an individual agent, when liable to a third party, may be available as a source of recovery when the principal on whose behalf the agent acted is not.²⁶⁵

The goals of accountability, fairness, and increase potential for full compensation are served if the claims intermediary is subject to claims in apt situations. Further, it appears to be the case that in operation, the intermediary is effectively the insurer. It is discordant for the law to impose substantial obligations and potential liability on insurers as principals but then to simultaneously prohibit actions against their agents, agents who often have independent, almost unsupervised authority over the claims process.²⁶⁶

²⁶⁴ See *Hamill v. Pawtucket Mut. Ins. Co.*, 892 A.2d 226, 230-31 (“[I]n most cases, imposing tort liability on independent adjusters would create a redundancy unjustified by the inevitable costs that eventually would be passed on to insureds”); see also *Meineke v. GAB Bus. Servs., Inc.*, 991 P.2d 267, 271 (Ariz. Ct. App. 1999) (“If the adjuster mishandles the claim, the insurer has the same liability to the insured as if an employee of the insurer had mishandled the claim.”).

²⁶⁵ See RESTATEMENT (THIRD) AGENCY § 7.01 cmt. b (2006).

²⁶⁶ Some of the majority rule states shrink from imposing intermediary liability on the ground that the applicable state law “only allows an insured to sue an insurer for bad faith and not simple negligence.” *King v. Nat’l Sec. Fire & Cas. Co.*, 656 So. 2d 1338, 1339 (Fla. Ct. App. 1995). In my view, this misunderstands the distinction between bad faith and “mere” negligence. Insurers do not act in bad faith simply because they make mistakes. However, where an insurer intentionally adopts a coverage position that is both mistaken and objectively unreasonable, bad faith takes place. This type of bad faith is essentially a type of negligence that differs from ordinary negligence not because it is done with evil intent per se but

In addition, the relative immunity of claims agents seems incongruous when contrasted to the relatively large exposure to third party claims faced by sales agents, brokers, attorneys, accountants and attorneys. The rationale for the majority rule for claims intermediaries – that adjusters as agents have duties to the principal that are too inherently in conflict with any purported duty to third parties²⁶⁷ – has not prevented actions against other entities with substantial duties of loyalty toward a principal.

In these other professional or semi-professional relationships, there often is no formal written contract between the third party and the intermediary (as is the case with the insurance policy, insurer, and policyholder) but courts have recognized a duty to the claimant because of the nature of the activities of the agent-defendants. The sales agent has an implied contract to provide services and has tort-based duties not to mislead or disserve the applicant or policyholder. The broker often has not only contract obligations but also obligations implied by statute or common law. Accountants as agents do work for their principals that they know will be relied upon by others and for that reason are usually held liable if their negligence misleads those relying on their work. Other actors without contracts may be responsible to others as a matter of tort law.²⁶⁸

because the negligence (in the form of unreasonable policy interpretation or conduct) takes place over an extended period of time. It is not like the split-second of driving negligence that can create tort liability but it is a type of negligence nonetheless, even though the legal system has given it the much more sinister-sounding name of bad faith.

²⁶⁷ See, e.g., *Meineke*, 991 P.2d at 270 (Ariz. Ct. App. 1999); *King*, 656 So. 2d at 1339 (Fla. Ct. App. 1995); *Velastequi v. Exch. Ins. Co.*, 505 N.Y.S.2d 779, 780 (N.Y. Civ. Ct. 1986).

²⁶⁸ See *Glanzer v. Shepard*, 135 N.E. 275, 276-77 (N.Y. 1922). In this case, Judge Cardozo and the New York Court of Appeals found that a merchant could be liable for injury caused by inaccurate weighing of goods sold. Later, in *Ultramares Corp. v. Touche*, 174 N.E. 441, 449-50 (N.Y. 1931), Cardozo and the court were unwilling to extend the same analysis to public accountant auditors, a result that has been significantly criticized and ultimately was rejected by the RESTATEMENT (SECOND) OF TORTS § 552 (1977). See also *Moch Co. v. Rensselaer Water Co.*, 247 N.Y. 160, 168 (N.Y. 1928) (finding no liability for service interruption that adversely affected the general public but not persons who were intended third party beneficiaries of a contract). Cardozo became fonder of constricted tort liability as he aged. See *Palsgraf v. Long Island R.R.*, 162 N.E. 99 (N.Y. 1928), another result that has netted criticism and not been universally followed in other states. See

In nearly all states, a policyholder victimized by poor attorney defense of a claim subject to liability insurance has a right to sue for damages even though there may not be a formal written contract between these entities and the policyholder. Rather, a contract is implied in many of these relationships, particularly the attorney-client relationship that results from liability insurer defense of a third party's claim against the policyholder. In many states, the insurer may sue the attorney for malpractice even though the primary attorney-client relationship is between lawyer and policyholder (although there is clearly a contract between insurer and defense attorney).²⁶⁹ Even where counsel is adverse and where sensitive information is acquired through the representation of a client, an attorney is sometimes permitted to disclose it (over the client's objection) to the opponent²⁷⁰ and may arguably have an obligation to do so.

generally JOHN T. NOONAN, SR., *The Passengers of Palsgraf in PERSONS AND MASKS OF THE LAW* (1976).

²⁶⁹ See generally STEMPER, *supra* note 27, at § 9.03[A]. See, e.g., *Paradigm Ins. v. Langerman Law Offices*, 24 P.3d. 593, 601-02 (Ariz. 2001) (finding that an insurer may bring a malpractice suit against an attorney it retained to represent a policyholder in an underlying tort litigation even though the attorney's primary client is the policyholder); *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 628-29 (Tex. 1998) (holding that a policyholder may not hold an insurer vicariously liable for an attorney's alleged malpractice because the attorney represented the policyholder and was obligated to exercise independent professional judgment rather than robotically follow insurer's direction).

²⁷⁰ See *Spaulding v. Zimmerman*, 116 N.W.2d 704 (Minn. 1962) (attorney who learns through adverse medical exam that plaintiff suing attorney's client has brain aneurysm not prohibited by lawyer confidentiality rules from disclosing condition to plaintiff so that plaintiff may get necessary medical attention). Presumably, the examining physician would also be permitted to make this disclosure.

I would even argue that both the lawyer and the doctor were required to make the disclosures in order to protect the health and life of the plaintiff. Even though the plaintiff was not a client or patient, the circumstances gave rise to a duty to at least tell plaintiff if they learned anything important about his medical condition that was relevant to future treatment.

Whether the doctor or an insurer retaining the doctors can be held responsible for failing to detect an aneurysm like that in *Spaulding v. Zimmerman* is a different and more difficult question. See, e.g., *Basil v. Wolf*, 935 A.2d 1154 (N.J. 2007). The court held that Ms. Basil, widow of a decedent worker examined by a doctor

for an independent medical examination as part of workers compensation claim adjustment, did not have claim against the insurer for the doctor's failure to make timely diagnosis of decedent's spindle cell tumor that eventually became Stage IV Sarcoma that killed decedent some 30 months later. *Id.* at 1172. Neither did Ms. Basil have a negligence claim against Dr. Wolf as medical intermediary working for the insurer. *Id.* at 1176. The court viewed the doctor was retained by insurer only for limited evaluative purposes and that the insurer was not providing medical treatment to Mr. Basil. *Id.* at 1172. A separate medical malpractice claim against Dr. Wolf individually was settled.

Basil v. Wolf is a problematic opinion. On one hand, Dr. Wolf was not exactly Dr. House (the brilliant but irascible character in the television series of the same name). Dr. Wolf initially diagnosed Mr. Basil as having a "probable hematoma" that should be treated by physical therapy. Basil sought an MRI or x-ray prior to beginning any regime of physical therapy, presumably because he wanted to make sure there was not a more serious problem or something that would counsel against therapy. On the other hand, Dr. Wolf did in a subsequent visit recognize that the condition was getting worse and that an x-ray was the "logical" next step. The x-ray was negative and an MRI recommended. But the x-ray did not take place for months and Dr. Wolf did not authorize an MRI until months after that. Although Dr. Wolf, a retired orthopedic surgeon who had canceled his malpractice coverage upon becoming an evaluator/consultant (which suggests the Ms. Basil did not get a big medical malpractice settlement), can be said to have had only a limited assignment as an agent of the insurer, it is a little hard to square this characterization of his and the insurer's role with what seems to be Dr. Wolf's practical power as a gatekeeper for the insurer and the insurer's practical power over the treatment Ms. Basil received.

The slow pace of diagnosis and treatment, seemingly spurred by Ms. Basil's retention of legal counsel, hardly makes a strong case for immunizing either Dr. Wolf or the insurer. The case was decided on summary judgment, with the New Jersey courts taking the view that there were no material contested facts requiring trial. This is pretty broad immunity to give an insurer or an agent of Dr. Wolf's type as a matter of law in view of their important role in examining the health of a person in connection with a claim of this sort. Even if this was in the context of a contested workers compensation claim, it still seems overly forgiving to excuse the insurer or the doctor as a matter of law and find that Mr. Basil was not really enough of a "patient" to have the protections of medical malpractice law. Although permitting an independent action for malpractice against the doctor may be enough of a correction in most cases, *Basil v. Wolf* appears to provide too little incentive for intermediaries or insurers to take seriously their reasonable obligations to claimants.

Courts have divided as to whether insurers are vicariously liable for the conduct of defense counsel retained and directed by an insurer²⁷¹ and have also divided as to whether a third party other than the client or insurer may sue insurer-provided defense counsel. Where attorneys have escaped liability to third parties, this has generally been based upon the rationale that the attorney’s duty of fiduciary loyalty and zealous representation on behalf of a client (even a misguided or unreasonable client) makes it inappropriate to dilute this loyalty or create a countervailing loyalty by permitting tort actions against counsel by third parties.²⁷² Although this may be a reasonable if problematic assessment

²⁷¹ See *Rose v. St. Paul Fire & Marine Ins. Co.*, 599 S.E.2d 673, 682-86 (W. Va. Ct. App. 2004) (collecting cases finding vicarious liability and cases rejecting it) (also noting that some states permitting vicarious liability may require actual insurer knowledge of attorney misconduct while others will permit liability through imputed or constructive knowledge of attorney misconduct by insurer). See also *Horwitz v. Holabird & Root*, 816 N.E.2d 272, 287 (Ill. 2004) (noting same split in jurisdictions)

After careful consideration of this conflicting authority, we conclude that when, as here, an attorney acts pursuant to the exercise of independent professional judgment, he or she acts presumptively as an independent contractor whose intentional misconduct may generally not be imputed to the client, subject to factual exceptions. *Id.* at 278.

In reaching its holding, the *Horwitz* Court noted that its view conflicted with the RESTATEMENT (SECOND) OF AGENCY § 253, which provides in Comment a that “[t]he fact that the attorney is subject to discipline by the court does not prevent the client from being liable for his [tortuous] conduct.” See *id.* at 280. The Court further noted that it disagreed

with the Restatement’s discounting that attorneys are constrained by certain court-imposed ethical considerations that serve to distance their behavior from their clients. Attorneys cannot blindly follow their clients’ directions, even if those directions are particular and express, if doing so would require them to violate their ethical obligations.

See *id.* at 280.

²⁷² See, e.g., *Horwitz*, 816 N.E.2d at 277, 284. The *Horwitz* Court itself was divided in that three judges dissented. See *id.* at 284 (McMorrow, J., dissenting, joined by Garman, J.) (finding sufficient agency relationship to support vicarious liability even though attorney was independent contractor); *Id.* at 297 (Freeman, J. dissenting) (favoring application of *Restatement (Second) of Agency* § 253 to situations such as instant case). *Id.*

where attorneys are involved, it is not an apt approach for viewing the relation of insurer and claims intermediaries. The claims intermediary has duties to the insurer as principal but they are not of the same degree and magnitude as those of the attorney to a client.

More important, these divided cases focus on the issue of vicarious liability of the principal for the agent's acts. All states appear to recognize that the attorney can be individually liable for misconduct when representing the policyholder's interests notwithstanding the attorney's fiduciary responsibilities to the insurer as either client or as agent to principal.

Ironically, in at least one state (Washington), a claims adjuster that engages in conduct too tinged with legal analysis and activity (e.g., document drafting) may be liable for de facto malpractice and unauthorized practice of law²⁷³ – but if the adjuster is merely negligent, the protections of the traditional lack-of-privity/disclosed principal approach would appear to apply.²⁷⁴ In other states, claims intermediaries, particularly public adjusters (nonlawyers who represent policyholders in advancing first party property claims against with insurers) are sometimes held to be engaged in unauthorized practice of law.²⁷⁵

²⁷³ See *Jones v. Allstate Ins. Co.*, 45 P.3d 1068, 1079 (Wash. 2002). In *Jones*, however, the adjuster found to have engaged in unauthorized legal practice appears to have been an Allstate employee. Presumably, however, the court's analysis would be equally applied to independent contractor adjusters.

In addition, *Jones* introduces an interesting complexity to Washington law. Adjusters practice law if they give legal consultation or prepare legally operative documents such as the release at issue in *Jones*. However, the court (in a 5-4 decision) ruled that insurance companies using adjusters in this way could continue but that they would be liable to third parties interacting with the adjuster-cum-lawyer if the adjusters' activities fell below the standard of care for a lawyer in similar circumstances. The adjuster in question *Jones* was found to have fallen beneath this standard. *Id.* at 1079.

²⁷⁴ See *Kim v. O'Sullivan*, 137 P.3d 61, 64-5 (Wash. App. Ct. 2006) (policyholder defended by insurer-selected attorney could not assign malpractice claim to third party bringing suit nor could anti-assignment rule be circumvented by third party's prosecution of malpractice claim; insurer-retained attorney could not be sued for bad faith like insurer). *Id.*

²⁷⁵ See, e.g., *Utah State Bar v. Summerhayes & Hayden*, 905 P.2d 867, 872 (Utah 1995); *Prof'l Adjusters, Inc. v. Tandon*, 433 N.E.2d 779, 780 (Ind. 1982).

But unlike actual lawyers, adjusters who avoid this pitfall, particularly adjusters working as insurance company employees rather than independent contractors, are considerably better protected from liability than real lawyers or adjusters drafting releases. Further, real lawyers have very strong fiduciary duties to clients, sometimes multiple clients, and play an inherently more adversarial, judgment-laden role in the dispute resolution system. Logically, attorneys should have more protection from liability to third parties (but not from their client-principals) than do TPAs and independent adjusters. But in majority rule states, they have less. Something is wrong with this picture.

Recognizing the relationship of insurance intermediaries to policyholders as one supporting tort liability for harm inflicted would put intermediary exposure on a par with that of other actors who conduct activities upon which a reasonably discreet and identifiable number of third parties are known to rely and likely to suffer injury if those activities are negligently performed.²⁷⁶ Similar results could be supported by a

²⁷⁶ For example, in the significant, now venerable case *Biakanja v. Irving*, 320 P.2d 16, 19 (Cal. 1958), the court concluded that a notary public could be held liable to an intended beneficiary for negligent attestation of a will. In reaching this result, the court considered several factors in order to determine whether the notary should owe a duty to parties with whom he did not contract: (1) the extent to which the transaction was intended to affect the claimant; (2) the foreseeability of harm to the plaintiff; (3) the degree of certainty that plaintiff suffered injury (from the defendant's errors); (4) the closeness of the connection between defendant's conduct and the injury; (5) the moral blame reasonably attached to defendant's conduct; and (6) public policy considerations regarding incentives for preventing future harm. *Id.* at 19. See also *Bus to Bus. Mkts, Inc. v. Zurich Specialties London, Ltd.*, 135 Cal. App. 4th 165, 168, 37 Cal. Rptr. 3d 295, 297 (Cal. Ct. App. 2005) (reaffirming state's use of *Biakanja* factors for determining actor's liability to third parties).

This is not a bad set of criteria for determining the existence of duty to third parties in the absence of a contract. As discussed above (*see supra* text accompanying notes 198-204), it often results in liability for accountants, attorneys, engineers, and others who conduct activity that they know will impact others in a non-attenuated way or where third parties are expected to rely on the activity of the professional or intermediary.

Applied to claims intermediaries, the *Biakanja* factors would tend to support liability because (1) the entire adjusting transaction is intended to benefit the policyholder at least as much as the insurer (because the insurer has a non-delegable duty to give equal consideration to the policyholder's interests) and also to benefit, at least to a degree, third party claimants and society; (2) harm from

reasonably broad approach to the question of intended third party beneficiaries of contract.²⁷⁷

C. A WORKABLE STANDARD OF INTERMEDIARY LIABILITY

One valid concern underlying the traditional approach protecting claims intermediaries from liability is the view that it is unfair to hold agents accountable for errors commanded by the principal. For example, the adjuster denying a claim may itself have recommended payment and merely been the bearer of bad news when it informed a policyholder or claimant that coverage was denied by the insurer. In other situations, the adjuster may have had only a limited investigatory role and no evaluative role.

Although these are valid concerns, they do not logically support a blanket rule of intermediary immunity. Rather, these cases suggest that claims agents should not be strictly or vicariously liable for insurer misconduct or error. Intermediaries should be liable not merely because of an insurer's bad conduct or decision but should instead be potentially liable

adjuster negligence is foreseeable; (3) harm is often certain where adjusters act negligently or intentionally deny or recommend denial of a claim without proper basis; (4) the adjuster's conduct and an adverse outcome are often closely linked; (5) many adjuster failures are morally blameworthy, particularly in light of their status as agents for a principal that owes a fiduciary-like duty of good faith; and (6) public policy favors holding negligent adjuster accountable in order to discourage errors and their attendant harm.

²⁷⁷ The historical rule is that a "third party should not be permitted to enforce covenants made not for his benefit, but rather for others [because the third party] is not a contracting party [and] his right to performance is predicated on the contracting parties' intent to benefit him." *See Jones v. Aetna Cas. & Sur. Co.*, 33 Cal. Rptr. 2d 291, 295 (Cal. Ct. App. 1994) (citations omitted). Although this may logically prohibit a policyholder landlord's tenant from claiming benefits under the landlord's property insurance policy, the rule should not bar a policyholder from being able to obtain compensation when injured by the actions of a claims adjuster that was retained by the insurer to vindicate the interests of the policyholder under the insurer's policy. Unlike many third parties, the policyholder clearly was intended to benefit from an important contract with the principal and retains rights under that contract even if the principal has outsourced the claims function to an intermediary.

only where a plaintiff has alleged negligence or some greater quantum of wrongdoing by the intermediary.

Already, the majority rule has been relaxed enough that most states permit actions against claims intermediaries where the intermediary and the insurer can be said to have operated as something like a joint venture, particularly where there is some sharing of financial risk.²⁷⁸ Several other jurisdictions have moved toward permitting intermediary liability under what might be termed a management theory, permitting claims where the intermediary conducts the basic administrative functions of an insurer and has discretion to determine claims outcomes even if the intermediary and the insurer lack sufficient financial links to be deemed a joint venture.²⁷⁹

From these already reasonably well established extensions of liability in derogation of the historical rule, it is only a relatively small step toward simply making intermediaries liable under basic tort principles of duty and negligent breach causing damages. Although only a few states (perhaps only Alaska and New Hampshire) support this approach,²⁸⁰ it is the most sensible means of consistently holding intermediaries accountable and creating adequate incentives for intermediary care.

This proposed approach would not create undue burden on downstream intermediaries or dramatically expand litigation and business transaction costs. The likely additional cost of a negligence regime for policing the actions of claims intermediaries will probably be modest in relation to the gains of greater intermediary care resulting in fewer problems and greater settlement of claims.

²⁷⁸ See *supra* text and accompanying notes 77, 87-92.

²⁷⁹ See *supra* text and accompanying notes 78-82, 81-93. Although it is not often invoked, this principle is sufficiently established that it has in the past appeared to me that this was in fact the general rule: adjusters sufficiently acting as the “functional equivalent” of the insurer may be liable to at least insureds and policyholders and perhaps to claimants under certain situations. See *Stempel on Insurance Contracts*, *supra* note 27 at § 10.02[A] p. 10-17. Further examination of the issue in this article suggests I might have been overbroad in that statement because of the tendency of some courts not to recognize an exception to the privity and disclosed agency defenses even where the administrator or adjuster has assumed the functions of the insurer. In general, however, it appears most jurisdictions will permit liability upon a sufficient showing of adjuster activity as an insurer, particularly if there is financial intertwinement or risk sharing.

²⁸⁰ See *supra* text and accompanying notes 75-82.

Consistent with the general rule of § 7.01 of the current *Restatement* and its predecessors, an intermediary cannot avoid liability if its conduct is tortious simply because the conduct was committed in the service of the insurer. However, where an intermediary can demonstrate that it had no discretion in its conduct and that the conduct was completely controlled by the insurer/principal, adherence to the traditional majority rule remains appropriate.

In practical application, this means that many, perhaps most, cases will result in claims against intermediaries surviving motions to dismiss as a matter of law. In the modern real world of insurance law, insurers delegate substantial authority to claims intermediaries as independent contractors. Typically, the intermediary has control over the quality and quantity of investigation conducted, evaluation of the claim, and communication with claimants and policyholders. If the intermediary does not conduct these activities in an objectively reasonable manner (as would a hypothetically reasonable adjuster in that situation), a claim for negligence should lie. But it hardly follows that adjusters who act reasonably will be routinely sued. If they are, they can counterattack via Rule 11 motions or similar measures designed to discourage frivolous claims.²⁸¹ At a minimum, adjusters acting reasonably, although perhaps forced to defend more cases because of relatively liberal notice pleading and Rule 12 motion practice standards,²⁸² are unlikely to ever be wrongfully held liable.²⁸³

²⁸¹ See Fed. R. Civ. P. 11 (imposing sanctions on litigants and counsel under apt circumstances if claim is not factually supported or legally cognizable); 28 U.S.C. § 1927 (permitting imposition of sanctions against litigants or counsel that unnecessarily prosecute unfounded claims). See also ROGER S. HAYDOCK, DAVID F. HERR & JEFFREY W. STEMPEL, *FUNDAMENTALS OF PRETRIAL LITIGATION* §§ 3.5, 11.5 (7th ed. 2008).

²⁸² Although pleading and motion to dismiss practice is still relatively pro-plaintiff, recent developments have shown that courts are perfectly capable of dismissing claims that are inadequately pleaded or present a far-fetched legal theory of relief. See HAYDOCK, HERR & STEMPEL, *supra* note 211, §§ 3.3, 4.1-4.4. Arguably, the modern ethos, at least in federal court, is too nitpicking in its desire to see the complaint plead sufficient facts to support a reasonable chance of litigation success. See, e.g., *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007) (dismissing complaint in antitrust action over dissent of Justices Stevens and Ginsburg).

Naturally, if the intermediary has engaged in misrepresentation, dishonestly, deceit, gross negligence, recklessness, or sharp practices, a liability claim logically should be permitted. If the intermediary has intentionally engaged in unreasonable conduct that deprives a policyholder

There has also been substantial academic criticism of *Twombly*. See, e.g., Kevin M. Clermont & Theodore Eisenberg, *CAFA Judicata: A Tale of Waste and Politics*, 156 U. PA. L. REV. 1553, 1561, 1592 (*Twombly* “imposed a plausibility test on pleadings, thereby discombobulating a basic area of law and managing to generate 2200 citations in its first five months.”); A. Benjamin Spencer, *Plausibility Pleading*, 49 B.C. L. REV. 431 (2008); Suja A. Thomas, *Why the Motion to Dismiss is Now Unconstitutional*, 92 MINN. L. REV. 1851 (2008). But see Keith N. Hylton, *When Should a Case Be Dismissed? The Economics of Pleading and Summary Judgment Standards*, 16 S. CT. ECON. REV. 39 (2008) (defending link between heightened review of disfavored antitrust claims at summary judgment stage and seeing *Twombly* as logically extending approach to pleading stage of litigation); Richard A. Epstein, *Bell Atlantic v. Twombly: How Motions to Dismiss Become (Disguised) Summary Judgments*, 25 WASH. U. J.L. & POL’Y 61 (2007) (similar view approving *Twombly* as reflecting heightened scrutiny given antitrust claims in summary judgment motion practice). Irrespective of whether criticism of *Twombly* is well-taken, it seems incorrect to say that motions to dismiss for failure to state a claim are toothless, particularly if the plaintiff is pursuing a relatively recently accepted cause of action such as a claim of insurance intermediary negligence. In addition, where the allegations of intermediary error are particularly weak, the case should logically be amendable to reasonably inexpensive disposition via summary judgment. See HAYDOCK, HERR & STEMPEL, *supra* note 211, § 12.3.

²⁸³ Because claims by third parties against claims intermediaries have historically not been permitted, even those jurisdictions that have relaxed or overturned the general rule have rendered decisions very protective of intermediaries in light of the facts of the disputes. See *supra* text and accompanying note 79 and see *infra* text and accompanying notes 221-223 (discussing Oklahoma’s *Wathor* case and Mississippi’s *Jeffcoat* case). It is only logical that courts will at least subconsciously expect to see relatively substantial error or wrongdoing before holding a previously immune entity to account during the early decades of recognition of a “new” tort of intermediary negligence. At a minimum, adjusters are unlikely to lose weak cases both at trial and on appeal. For example, in *Jeffcoat*, the claimant was stripped of a jury verdict even though he adjuster’s conduct was horrendous. See *infra* text and accompanying notes 221-223. There is simply no good reason to expect that allowing tort claims against administrators and adjusters will produce an avalanche of judgments against these intermediaries.

of the benefit of the insurance bargain or that fails to give equal consideration to the interests of the policyholder, the adjuster should be subject to a bad faith claim.

In response to such claims, claims intermediaries should be required to defend on the merits if they are to avoid liability. One available defense for the intermediary – at least as respects only the decision to deny a claim -- would be that it acted solely upon the instruction of the principal and had no discretion to disobey. Although this is more forgiving standard than that applicable to most agents in tort cases, it would respond adequately to whatever core kernel of value might remain in the traditional approach. However, even if the adjuster was merely a conduit for the insurer's decision on coverage or payment, the adjuster should be subject to liability where it has been negligent (or worse) in its processing of the claim.

In addition, intermediaries might in some cases successfully defend on the slightly different ground that although the insurer did not exercise iron-fisted control or micromanagement of adjuster activity the nature and circumstances of the retention were sufficiently limited that the adjuster's conduct cannot be considered negligent or wrongful in context. This is similar to one majority rule court's sentiment that "[t]he independent adjuster's obligation is measured by the contract between the adjuster and the insurer. The adjuster that contracts to perform a \$200 investigation is not obligated to expend the same effort that might be reasonable for a fee of \$2000, nor is it obligated to continue when the insurer advises it to stop."²⁸⁴

This sensible case-specific view would prevent small, relatively blameless adjusters (who logically would have done little significant harm) from being saddled with potentially company-closing liability. Such a context-based defense is a permissible means of softening the edges of tort liability but does not support blanket immunity for claims intermediaries. Rather, it supports a general rule permitting third party actions against intermediaries under the well-established principles of tort law and adjudicating them with sensitivity to the overall facts of the adjuster's assignment and performance.

Independent contractor adjusters and insurers should not be permitted to institutionalize negligent or bad faith performance by knowingly or routinely contracting for adjuster activity and compensation

²⁸⁴ See *Meineke*, 991 P.2d at 271.

that is so low as to encourage insufficient care in the claims management process. Neither should an adjuster be insulated from liability where it stops investigating under circumstances where this is unreasonable under the circumstances or reflects a failure to give adequate attention to the interests of a policyholder.

Moving to wide recognition that insurance administrators and claims intermediaries can be liable for negligent infliction of injury to policyholders and other reasonably foreseeable claimants would also be a healthy step away from the current caselaw’s excessive focus on bad faith liability and recognize that an intermediary may do considerable harm even if not acting as an insurer and that even where bad faith liability is inappropriate, the intermediary should not be completely immune from the consequences of its actions.²⁸⁵

In addition, cases in some jurisdictions, although permitting claims against intermediaries under the heightened standards of management theory or joint venture, have exhibited perhaps an undue tendency to shrink from finding sufficient insurer-like conduct by the intermediary, effectively keeping the historical rule of adjuster immunity in place even in cases where the intermediary is doing insurer-like adjusting and should be held accountable for injury inflicted on foreseeable parties, particularly policyholders.²⁸⁶

²⁸⁵ This has been recognized over the years in cases rejecting bad faith liability for claims intermediaries but noting that other causes of action, such as a simple tort action sounding in negligence, may under apt circumstances be available to those injured by the intermediary. *See, e.g.,* Hudock v. Donegal Mut. Ins. Co., 264 A.2d 668, 672 n. 3 (Pa. 1970) (plaintiffs’ “allegations as to the adjusters and their agents might establish a cause of action in tort” but because instant action framed in contract, plaintiffs cannot recover due to lack of privity); Stone v. New Eng. Ins. Co., 39 Cal. Rptr. 2d 714, 731 (Cal. Ct. App. 1995) (inability to maintain claim under insurance contract or unfair claims practices statute may not foreclose other claims sounding in tort or based on other statutes).

²⁸⁶ For example, in *Wathor v. Mut. Assur. Admin*, 87 P.3d 559 (Okla. 2004), discussed *supra* text and accompanying notes 79, 84-86, the court found – as a matter of law – that the administrator in question had not acted sufficiently like an insurer to permit the insured to bring a claim against the administrator even though the facts as set forth in the case report would appear to permit a reasonable inference that the administrator had been delegated the bulk of the entire claims function by the insurer. *See id.* at 563 (“[administrator] unquestionably performed some of the tasks of an insurance company in its claims handling process”).

The problem with requiring a financial pooling of risk as a prerequisite to administer or adjuster liability is that it fails to appreciate the degree to which claims intermediaries have plenty of incentive to mistreat policyholders and other claimants under straight fee-for-service contracts. Like any vendor, an independent contractor claims intermediary wants to please the party that hired it in order to gain continued future employment and to continue to charge adequate prices. Even without formal risk sharing or economic partnership per se, the independent claims intermediary has substantial incentive to resist claims, knowing that this will save the insurer money (at least in the short run) and result in favorable reviews of the adjuster's work (and future business). Although substandard, overly stingy administration and adjusting may result in successful litigation against the insurer, this does not provide sufficient incentive for optimal adjuster care, certainly not adjuster behavior that gives equal consideration to the interests of policyholders.

First, any litigation consequences of adjuster misconduct are likely to come years after the misconduct. By this point, the adjuster will have already attained financial reward from taking a hard line against claims and the relationships between the intermediary and insurer personnel are often sufficiently close that the insurer is unlikely to hold the adjuster accountable and to replace the adjuster. In addition, by this point, insurer and adjuster may be in a "trench warfare mentality" where even after an

Although the court majority put great stock in the insurer's apparent final say as to claims payment, the dissent correctly noted that the rule of *Restatement (Second) of Agency* § 343 was that an agent committing a tort is not relieved of liability simply because the agent's tortious action was commanded by the principal or "on account of the principal." See *id.* at 565 (Opala, J. and Watt, J., dissenting).

The majority was unmoved, however, finding liability inappropriate because the administrator did not have its compensation package expressly tied to the approval or denial of claims and "did not share the risk of loss with the [insurer, here an employer's health plan]. As discussed in text, the requirement of financial risk sharing and entrepreneurial partnership as a prerequisite for administrator liability is unnecessarily demanding.

Equally disturbing is that the court never addressed *Brown v. State Farm Fire & Cas. Co.*, 58 P.3d 217 (Okla Ct. App. 2002), which recognized that independent investigators and adjusters could be liable under simple tort and negligence principles based on duty created by their relation to policyholders and the foreseeability that inadequate claims processing could injure the policyholder. *Brown* was not even cited in passing by the *Wathor* Court. See generally *id.*

adverse judgment they continue to fail to see what was done wrong in dealing with the policyholder or claimant.²⁸⁷

Second, and perhaps more troubling but more difficult to ascertain is the prospect that the insurer, which profits from delay in claims resolution and the time value of money, silently is happy to have adjusters take an overly hard line. As previously discussed,²⁸⁸ this permits the insurer to “have it’s cake” (funds that do not have to be paid until after an adverse court decision) and “eat it, too” through minimizing its potential bad faith exposure by pointing the finger at the claims intermediary as the actual active agent of misconduct or the purveyor of bad investigation or evaluation that led the insurer astray. In return for continuing to receive business from the insurer, the claims intermediary can, under the current regime, act as the insurer’s foil because it is unlikely to be held accountable under the law unless it has sufficiently supplanted the insurer, perhaps even rising to a level of a joint venturer.

For these reasons, subjecting independent adjusters and administrators to the same tort regime that largely governs everyone else and their activity seems both modest and justified. A compromise position of sorts would be like that of Mississippi, which immunizes intermediaries from claims sounding only in negligence but may find liability where there was been gross negligence, recklessness, or some misconduct greater than negligence. Although this would be an improvement over the traditional approach, it still permits too much avoidance of responsibility and too little incentive for claims intermediaries. Cases decided under this heightened standard of requiring “more than negligence” can exhibit an alarming tendency to characterize even outrageous behavior or missteps as only mere negligence.

For example, in *Gallagher Bassett Services, Inc. v. Jeffcoat*,²⁸⁹ the Mississippi Supreme Court held (albeit over a strong dissent) that there was

²⁸⁷ Perhaps most amazingly and notoriously, the insurer and its agents involved in the famous *Campbell v. State Farm* litigation, despite having been held to have acted in bad faith for egregious failure to settle a resolvable claim and protect the policyholder, including a \$145 million punitive damages award (eventually reduced to \$9 million) continued to maintain for more than 25 years that nothing wrong had been done. See STEMPEL, LITIGATION ROAD, *supra* note 27, chs. 10, 14-23 (2008).

²⁸⁸ See *supra* text and accompanying notes 146-47.

²⁸⁹ *Gallagher Bassett Servs., Inc. v. Jeffcoat*, 887 So.2d 777 (Miss. 2004).

as a matter of law nothing worse than negligence in a situation where the adjuster: misrepresented its activities to the claimant; withheld assessing the amount of coverage until receipt of a legal opinion; never requested the legal opinion; was not licensed in Mississippi; was not trained in Mississippi insurance principles, in particular the question of “stacking” of policy coverages that was at the core of the dispute; and failed for months to take any concrete action to acquire necessary knowledge that it did not have (including failing to insist that the insurer provide necessary information).²⁹⁰ The evidence of gross negligence, reckless, or intentional dereliction of duty by the adjuster was substantial albeit contested (both the adjuster and the plaintiff presented dueling expert witnesses) but this did not stop the *Jeffcoat* majority from overturning a jury verdict in Plaintiff Jeffcoat’s favor. So much for the protection provided policyholder’s under the “gross negligence” standard of care for claims intermediaries.²⁹¹

²⁹⁰ *See id.* at 780-83.

²⁹¹ In fairness to the Mississippi Supreme Court, at least the case was a close one, essentially decided as a 4-3 opinion (a three-member majority opinion, one concurring justice, and three dissenters). *See id.* at 789. The majority’s reluctance to uphold a sizeable verdict against the adjuster may also have been fueled by simple legal realism in that Plaintiff Jeffcoat had already received \$1.8 million in compensation from his injuries from the insurer. Just the same, even the majority’s description of the adjuster’s performance seems to suggest something more than mere negligence. For example:

Gallagher did not provide training or resources to support its adjusters’ work on uninsured motorist claims. Gallagher failed to give its adjusters any resources or training regarding stacking in Mississippi. Although she was generally familiar with stacking, [Gallagher adjuster Juana] Love did not know that stacking was available in Mississippi or how it works until Jeffcoat’s lawyer informed her that it is and explained how it works. Love knew that she needed a legal opinion on this issue, but she failed to request one. It escapes us why Love would wait until the [policyholder’s truck] fleet schedule was discovered to request an opinion. Clearly, Love could have obtained a legal opinion on whether and how stacking applies in Mississippi without knowing the number of vehicles in the [policyholder’s] fleet.

* * *

Gallagher’s adjustment of this claim evinces a complete breakdown of communication and cooperation between two contractually obligated parties, supervisors and subordinates within Gallagher, as well as between two principals and their agent. Important documents related to this policy were not shared with Gallagher either by accident or willfully. The [insurance] carrier’s

V. CONCLUSION

Treating insurance intermediaries as mere agents for disclosed principals without contract obligations to policyholders or claimants once arguably made sense and still arguably makes sense to the limited degree that it this approach prevents the intermediary from becoming liable in contract to insurance policyholders and other third parties or vicariously liable for the misconduct of insurers. Increasingly, however, the historical approach of intermediary immunity has become an anachronism in view of the substantial outsourcing of traditional insurer functions to independent contractor intermediaries. In addition, the traditional contract immunity of these intermediaries should never have been permitted to evolve into a de facto immunity from tort liability in cases where intermediary negligence or other misconduct foreseeably injures policyholders or other third parties within the intermediary’s zone of duty.

Many courts have begun to recognize the problem and impose liability upon intermediaries who in effect function as insurers themselves rather than mere agents or that are in joint venture-like financial connection with insurers. However, this continues to leave these important actors of modern insurance under-policed to the detriment of policyholders, consumers, and society. Widespread adoption of the tort law approach advocated in this article would improve the incentive structure of intermediary activity and align it with that of insurers and similarly situated social actors, encouraging more consistently apt claims practices.

representatives were uncooperative with Gallagher, bringing the resolution of Jeffcoat’s claims to a standstill or as Love described it, an “impasse.”

See id. at 784-85.

Not surprisingly, a jury of presumably rational persons viewed this situation as something more than mere negligence. The state supreme court’s overturning of this reasonable verdict as a matter of law suggests that Mississippi’s “more than negligence” standard for imposing liability on adjusters is simply too malleable and likely to result in courts straining to avoid adjuster liability. By contrast, a negligence standard would be less susceptible to judicial manipulation.

DIFFERENTIAL COMPENSATION AND THE “RACE TO THE BOTTOM” IN CONSUMER INSURANCE MARKETS

Daniel Schwarcz*

This contribution to a symposium on insurance intermediaries analyzes insurers' compensation of independent agents and brokers in consumer markets. It focuses on various forms of "differential compensation," whereby an intermediary's compensation differs depending on the insurer with which the consumer ultimately purchases coverage. Such differential compensation, the article argues, undermines competition among consumer insurers with respect to non-price product attributes. This, in turn, increases the risk of a "race to the bottom" in consumer insurance markets, as insurers focus on selling the cheapest coverage possible that is consistent with legal restrictions. To address these problems, this article suggests that insurers who rely on independent agents to sell consumer lines of insurance should be prohibited from paying different rates of compensation to different agents for the sale of the same line of insurance.

In 2004, a series of lawsuits filed by the New York Attorney General challenged insurers' long-standing payments of year-end bonuses to insurance brokers. The lawsuits alleged that these payments, known as contingent commissions, created conflicts of interest that undermined

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brokers' professed loyalty to their clients.¹ "If the practices identified in our suit are as widespread as they appear to be," the Attorney General stated, "then the industry's fundamental business model needs major corrective action and reform."²

Within months of these allegations, the commercial insurance industry had indeed changed significantly. Each of the four largest insurance brokers pledged to end their practice of accepting contingent commission payments from insurers.³ Because of the concentration of the insurance brokerage industry – the three largest brokers, Marsh, Aon, and Willis enjoyed more than a 54% market share among the top 100 brokers in 2004⁴ – this shift dramatically impacted the entire market. Meanwhile, the prominence of these allegations led corporate risk managers and other sophisticated insurance purchasers to demand from their brokers previously-undisclosed details about contingent commission arrangements.⁵ Although many small brokers still accept contingent commissions, many other brokers (including the four largest) now publicly tout their refusal to accept such commissions in marketing themselves to their clients.⁶

¹ See generally Sean M. Fitzpatrick, *The Small Laws: Eliot Spitzer and the Way to Insurance Market Reform*, 74 FORDHAM L. REV. 3041, 3047 (2006) (reviewing the trajectory of Attorney General Spitzer's investigation of contingent commissions); Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL'Y REV. 289 (2007).

² Press Release, Eliot Spitzer, New York Attorney Gen., Investigation Reveals Widespread Corruption in Insurance Industry (Oct. 13, 2004), available at http://www.oag.state.ny.us/press/2004/oct/oct14a_04.html.

³ See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 291-92.

⁴ See J. David Cummins & Neil A. Doherty, *The Economics of Insurance Intermediaries*, 73 J. RISK & INS. 359, 364 (2006).

⁵ See David Dwanka, *Mid-Level Insurance Brokers Defend Contingent Commissions Amid Growing Criticism*, BESTWIRE, May 8, 2006.

⁶ *Broker Compensation: Hearing Before the New York Ins. Comm'r* (2008) (testimony of Don Bailey, CEO of Willis) (testifying that Willis does not accept contingent commissions because they pose a "clear and obvious conflict of interest") available at http://www.ins.state.ny.us/agbrok/br_cmp_idx.htm.

For all of this reform in *commercial* insurance markets, virtually nothing has changed about the way intermediaries in *consumer* insurance markets are compensated. In both property/casualty and life/health consumer insurance lines, most independent insurance agents continue to receive increased compensation from insurers to whom they steer a significant amount of business.⁷ And, unlike sophisticated insurance purchasers, most consumers continue to have no real understanding of these practices and the impact they may have on the advice that insurance agents offer.

From a doctrinal perspective, this divergence in consumer and commercial insurance markets may appear to be perfectly reasonable. The insurance brokers that service commercial insurance markets are generally considered to be legal agents of policyholders.⁸ By contrast, the independent insurance agents that populate consumer insurance markets are usually described primarily as legal agents of insurers, rather than consumers, and therefore have more limited (if any) fiduciary obligations to policyholders.⁹ Consequently, compensation structures that create conflicts of interest appear to be more troubling doctrinally in commercial markets than in consumer markets.

But from an economic perspective, the differential reform in commercial and consumer insurance markets is bizarre. Unlike sophisticated commercial entities, ordinary consumers generally have limited information about the relative quality of different carriers and a bounded ability to translate the information they do have into effective decision-making.¹⁰ As Cass Sunstein and Richard Thaler recently observed, “the benefits from holding . . . insurance are delayed, the

⁷ See generally *id.*; see also Richard W. Cooper, *Spitzer's Allegations of the Anticompetitive Effects of Contingent Commissions: A Shot Truly Heard Around the World*, J. OF INS. REG. 83, 100 (2007).

⁸ See KENNETH S. ABRAHAM, INSURANCE LAW & REGULATION 56-57 (3d ed. 2000).

⁹ ERIC MILLS HOLMES, HOLMES' APPLEMAN ON INSURANCE 2D: LAW OF INSURANCE AGENTS § 47.5, at 326 (1998). See TOM BAKER, INSURANCE LAW AND POLICY 66 (2003); Colin Sammon, Comment, *Insurance Agent and Broker Liability: Crossing the Two Way Street*, 29 OHIO N.U. L. REV. 237, 238 (2002).

¹⁰ See Part II, *infra*.

probability of having a claim is hard to analyze, consumers do not get useful feedback about whether they are getting a good return on their insurance purchases, and mapping from what they are buying to what they are getting can be ambiguous.”¹¹ Consumers are therefore much more susceptible than commercial purchasers to being steered to insurance carriers they would not prefer under ideal market conditions.

Not only does such steering create mismatches between consumers and their insurers, but it undermines the competitiveness of consumer insurance markets as a whole. Although consumer insurance markets are ultra-competitive with respect to price,¹² they are remarkably non-competitive with respect to claims handling quality.¹³ Indeed, many consumer insurance markets appear to be characterized by insurer-side adverse selection, wherein price competition creates a race to the bottom among insurers with respect to claims handling quality.¹⁴ This Article argues that differential compensation contributes to this insurer-side adverse selection. By corrupting the objectivity of independent agents’ advice, differential compensation undermines the primary mechanism by which consumers can ordinarily overcome informational and cognitive limitations in assessing the quality of complicated financial products.

As such, this Article proposes that insurers who rely on independent agents to sell consumer lines of insurance should be prohibited from paying different rates of compensation to different agents for the sale of the same line of insurance. Such reform would be less radical than it may initially appear. Federal regulators have long regulated commissions

¹¹ CASS SUNSTEIN & RICHARD THALER, *NUDGE* 76-77 (2008).

¹² See J. DAVID CUMMINS, *DEREGULATING PROPERTY-CASUALTY INSURANCE* 2-3 (2002); Paul Joskow, *Cartels, Competition, and Regulation in the Property-Liability Insurance Industry*, RAND J. ECON. 375 (1973).

¹³ See Section II. B., *infra*.

¹⁴ Legal scholarship has long recognized that such price competition can cause firms to provide inefficiently poor quality when consumers cannot reliably evaluate quality due to information deficits or systematic cognitive limitations. See generally Oren Bar-Gill, *Seduction By Plastic*, 98 NW. L. REV. 1373, 1376 (2004); Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: The Problem of Market Manipulation*, 74 N.Y.U. L. REV. 630 (1999); Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: Some Evidence of Market Manipulation*, 112 HARV. L. REV. 1420 (1999).

for the sale of Medigap policies, and they recently announced their intention to do the same for Medicare Advantage programs.¹⁵ By extending these policies to the sale of all consumer insurance policies, lawmakers could provide consumers with the same protections that sophisticated commercial entities already enjoy. Even more importantly, they could enhance the competitiveness of consumer insurance markets as a whole.

I. INDEPENDENT INSURANCE AGENTS AND DIFFERENTIAL COMPENSATION

A. INSURANCE AGENTS IN CONSUMER INSURANCE MARKETS

Consumers can purchase insurance coverage directly from an insurer, or through either independent or captive agents. Captive agents are employees of a single insurer and only offer coverage with that carrier.¹⁶ By contrast, independent agents can write business with multiple insurers and consequently provide consumers with a choice of carriers.¹⁷ Such choice can be valuable for consumers, as insurers differ in terms of their reputations for claims handling, financial strength, risk management services, and scope of coverage offered.¹⁸ In addition to these variations in

¹⁵ See generally Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (limiting agent compensation so that first year compensation may not be greater than twice renewal compensation, renewal compensation must be paid for at least 5 years, and replacement commissions may not be greater than renewal commissions for the product); Press Release, Center for Medicare & Medicaid Services, CMS Proposes New Protections for Medicare Beneficiaries in Medicare Advantage and prescription Programs (May 8, 2008) available at <http://www.cms.hhs.gov/> (describing proposed regulation that would “require Medicare Advantage organizations to establish commission structures for sales agents and brokers that are level across all years and across all [Medicare Advantage] plan product types”).

¹⁶ HOLMES, *supra* note 9, at 326.

¹⁷ Cummins & Doherty, *supra* note 4, at 375.

¹⁸ See *id.*; Schwarcz, *Beyond Disclosure*, *supra* note 1, at 296-97. Independent insurance agents market themselves primarily on the basis of their capacity to help consumers compare these variations in quality and pricing. As the website of their main trade organization explains, independent agents “work with you to identify the insurance . . . that [is] right for you... and use [their] access to multiple

“quality,” insurers employ differing underwriting criteria and strategies, resulting in price differentials even in highly price competitive marketplaces.¹⁹

Consumers may prefer independent agents over captive agents for other reasons as well. First, many insurers do not offer insurance directly to consumers or distribute their products through captive agents, meaning consumers who want to purchase policies from these insurers must go through an independent agent.²⁰ Second, because independent agents “own” their customer lists, insurers cannot directly solicit the agent’s clients or switch those clients to a different agent. Some have argued that this ownership gives independent agents a comparatively strong incentive to serve their clients, though empirical efforts have failed to confirm this theory.²¹

Of course, there are offsetting costs associated with purchasing coverage through an independent rather than captive agent. First, just as some insurers only provide coverage through independent agents, many popular insurers, such as State Farm and Allstate, only offer coverage through captive agents.²² In general, these insurers tend to be more

companies to deliver those products.” Independent Insurance Agents & Brokers of America – Consumer Information, <http://www.iaaa.org>. A brochure designed by the National Association of Professional Insurance Agents similarly explains that “by shopping among various companies, your professional agent can find the best combination of coverage, price and service -- the best value for your insurance dollar.” National Association of Professional Insurance Agents, *Straight Talk about Choosing a Professional Insurance Agent*, <http://www.pianet.com/Publications/choosinganagentbrochure.htm>.

¹⁹ See, e.g., Meg Green, *Top of Their Game*, BEST’S REVIEW 26 (Dec. 2006) (describing how some of the most profitable property-casualty insurers focus on underwriting only particularly safe risks, and pass off some of the resulting cost savings to their insureds).

²⁰ See Laureen Regan & Sharon Tennyson, *Agent Discretion and the Choice of Insurance Marketing System*, 39 J. L. & ECON. 637, 639 (1996).

²¹ Helen Doerpinghaus, *An Analysis of Complaint Data in the Automobile Insurance Industry*, 58 J. Risk & Ins. 120 (1991); J. David Cummins & Stephen Weisbart, *The Impact of Consumer Services on Independent Insurance Agency Performance* (1977) (IMA Education and Research Foundation).

²² See Regan & Tennyson, *supra* note 20, at 638.

publicly visible, as large insurers can more easily support a captive distribution system and may also have greater advertising incentives.²³ Second, other things being equal, coverage purchased through captive agents will tend to be cheaper than coverage purchased through independent agents.²⁴ Because captive agents only work with one carrier, they spend less time on each sale, meaning that they receive lower commissions than independent agents.²⁵ These lower commission rates may result in lower premium rates for customers, as studies suggest that insurers pass through to consumers most of the cost of agent compensation.²⁶

B. DIFFERENTIAL COMPENSATION OF INDEPENDENT AGENTS

Independent agents are compensated through standard commissions on the premiums consumers pay for their coverage.²⁷ These “ordinary” commission rates have always varied based on the underlying line of insurance sold, as different lines of insurance require different levels of effort by insurance agents.²⁸ But, historically, these commission rates were relatively standard within specific insurance lines, as individual insurers offered a single commission rate to all agents. Although new insurers

²³ *Id.*

²⁴ Itzhak Venezia et. al., *Exclusive vs. Independent Agents: A Separating Equilibrium Approach*, 40 J. ECON. BEHAV. & ORG. 443, 444 (1999).

²⁵ See Regan & Tennyson, *supra* note 20, at 648-49.

²⁶ Cummins & Doherty, *supra* note 4, at 380-83. Competing factors, such as the improved quality of an insurer’s underwriting criteria which is caused by increased premiums, may offset this effect.

²⁷ See *id.* at 374. In property/casualty insurance markets, these commissions are generally the same each year that a consumer renews a policy, whereas commission rates tend to decrease over time for life insurance sales personnel. This creates its own conflicts of interest, which are beyond the scope of this Article.

²⁸ See *id.* at 374-75.

occasionally offered above-market rates to break into markets, competition ultimately ensured relatively uniform commissions within product lines.²⁹

In the last few years, the premium commissions that different insurers pay independent agents have begun to vary more significantly than in the past. Some insurers now negotiate their commission rates on an individual basis with agents, offering higher rates to agents that have historically directed a large volume of profitable business to the insurer.³⁰ As a result, many independent agents receive higher commission rates for selling policies from one insurer than another, despite competitive forces.

Even insurance agents who receive the same *premium commissions* from different insurers may nonetheless receive different *contingent commissions* from those insurers. Unlike differential premium commissions, insurers have long paid contingent commissions to independent agents.³¹ Contingent commissions are year-end bonuses that some insurers pay to independent agents based on the performance of the agent's book of business with that insurer.³² Most contingent commission contracts link this bonus to certain volume or profitability benchmarks for the agent's book of business. If the specified benchmarks are met, then the insurer pays the agent a contingent commission that usually is calculated based on the profitability and/or volume of the agent's book of business with that insurer.³³ In life and health markets, agents often receive these

²⁹ See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 301.

³⁰ See, e.g., <http://www.chubb.com/marketing/chubb7450.html>; MetLife, *Supplemental Compensation Plan*, <http://www.whymetlife.com>; Rupal Parekh, *Hartford the Latest to Offer Supplementals as Replacements for Contingent Commissions*, BUS. INS., 33 (July 2007).

³¹ See Fitzpatrick, *supra* note 1, at 3056 ("Contingent commissions have been used by insurers as an incentive mechanism for their agents for a century or more.").

³² *Id.*

³³ In general, the size of an intermediary's contingent commission is based on two variables: (1) the amount of insurance business that a particular intermediary refers to the insurer, as measured in total premiums; and (2) the profitability of that business, which is usually measured by the insurer's loss ratio on that business. In most cases, intermediaries are only entitled to contingent commissions if they meet threshold levels of both sales volume and profitability. See Jeffrey Wilder, *Competing for the Effort of a Common Agent: Contingency Fees in Commercial*

contingent commissions in the form of in-kind benefits, such as vacation trips, rather than monetary compensation.³⁴

However it is structured, differential compensation undermines independent agents' incentives to objectively present consumers with information about competing insurance options.³⁵ The reason is simple: they incentivize independent insurance agents to steer consumers to carriers based on considerations other than those customers' insurance needs and risk preferences. Most obviously, differential commissions encourage insurance agents to steer consumers to insurers who pay the highest commissions. But because differential commissions are almost always tied in some way to the volume and/or profitability of the agent's book of

Insurance 5 (U.S. Dep't of Justice, Antitrust Div., Econ. Analysis Group Working Paper No. EAG03-4, 2004), available at <http://ssrn.com/abstract=418061>. The loss ratio is the "ratio between premiums paid and losses incurred during a given period." BLACK'S LAW DICTIONARY 958 (7th ed. 1999). Premiums on both new policies and policy renewals are generally treated similarly in these calculations, which are almost always made on a yearly basis. Wilder, *supra*, at 5. In some cases, contingent commission arrangements may be based only on volume, not profitability. However, "the great majority of the arrangements covering the smaller intermediaries is based on the profitability of the business written or profitability and volume." Cummins & Doherty, *supra* note 4, at 379. Once intermediaries reach these qualifying levels, their commissions typically increase with better results along either dimension. See Wilder, *supra*, at 5.

³⁴ See, e.g., *Broker Compensation*, *supra* note 6, at 103-113 (testimony of F. James Ginnane) (describing various cruises to the Baltics, Sweden, Montreal and elsewhere that MassMutual paid based on annual production, and noting that "all of the carriers" he was familiar with offer similar trips), available at <http://www.ins.state.ny.us/agbrok/br-cmp-tran-buf.pdf>.

³⁵ Consumers who purchase insurance via a captive agent have already made a decision that they want to purchase their coverage with a particular carrier. This means they will often have already priced out several different carriers and, perhaps, asked neighbors or friends about their experiences with those carriers. By contrast, consumers who seek out coverage via an independent agent have typically not made any decisions about which carrier best suits their needs. Although they may have had a particular agent recommended to them, they generally do not even know which carriers the agent offers, much less the relative characteristics of those carriers. Rather, independent agents offer themselves to consumers as an alternative to comparison shopping among different insurers. They purport to do the comparative shopping for the consumer.

business with an insurer, they may also create more subtle steering incentives for agents.³⁶ For instance, they may lead agents to steer customers to an insurer that has a minimum-volume requirement on the cusp of being satisfied.³⁷ Alternatively, they may cause an agent who believes that a consumer is a “bad risk” to steer that consumer to an insurer with whom the agent does not have a differential commission arrangement tied to profitability.³⁸ Differential commissions may also increase premium costs for consumers.³⁹

II. THE DESIRABILITY OF A LEGAL RESPONSE TO DIFFERENTIAL COMPENSATION FOR INDEPENDENT AGENTS

Differential compensation of sales agents is common, and often understood to be relatively benign in many industries and market contexts. For instance, salespeople in retail stores may often receive special bonuses or in-kind benefits if they reach sales targets for particular products or brands. Like independent insurance agencies, such stores often carry multiple brands and consumers may rely on the advice of salespeople in making their decisions. Given that few suggest lawmakers regulate the compensation of sales personnel in these contexts, why would a different result be warranted in insurance markets?

Part of the answer is that consumer insurance markets are often regulated in ways that would be unthinkable in other markets. For instance, state insurance departments regulate product prices and designs and license salespeople and insurers.⁴⁰ Although the desirability of specific regulations

³⁶ See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 297-301.

³⁷ See Wilder, *supra* note 33, at 19.

³⁸ Cummins & Doherty, *supra* note 4, at 386-89. For this reason, agents who steer “high-risk” consumers to certain insurers may theoretically undermine their client’s interest by signaling to the insurer that particular consumers are relatively “high risk” and should thus be charged increased premiums. See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 324-35.

³⁹ See Cummins & Doherty, *supra* note 4, at 383.

⁴⁰ See generally ETLINGER ET AL., STATE INSURANCE REGULATION 103 (1995).

is often contentious, the notion that insurance requires robust market conduct oversight is generally accepted. The reasons are two-fold. First, consumer insurance markets are uniquely susceptible to market failure for a variety of reasons, including the complexity of the underlying product, the cognitive limitations of consumers, the prevalence of information asymmetries, and various other external forces that distort the market by, for instance, mandating the purchase of coverage. Second, the consequences of such market failure are significant. Consumers who have inadequate coverage typically do not discover that fact until after they have suffered a loss, at which point they no longer have the ability to mitigate their damages.⁴¹

This Part applies these general rationales for insurance regulation to differential compensation arrangements in consumer insurance markets. It concludes the market forces that ordinarily limit the pernicious effects of differential commissions are unreliable in consumer insurance contexts. Similarly, it suggests that the consequences of the resulting market failure are significant, contributing to a race to the bottom over claims-handling practices in many consumer insurance lines.

A. DIFFERENTIAL COMPENSATION AND MARKET FAILURE

In ordinary product markets, an intermediary's temptation to push expensive or high-margin products is counter-balanced by the potential for market backlash.⁴² At least some consumers are likely to arrive at a store with some knowledge about competing product options, especially given the wealth of such information available on the internet. This is particularly true with big-ticket items – like high definition televisions or cars – about which consumers will often invest time in researching. Attempts to steer such consumers to inferior or overpriced products may backfire, resulting in those consumers shopping elsewhere and sharing their

⁴¹ Bob Works, *Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture*, 5 CONN. INS. L. J. 505, 583-84 (1998).

⁴² Howell Jackson, *The Trilateral Dilemma in Financial Regulation*, in IMPROVING THE EFFECTIVENESS OF FINANCIAL EDUCATION AND SAVINGS PROGRAMS (Lusardi, Annamaria ed., forthcoming 2009); Howell E. Jackson & Laurie Burlingame, *Kickbacks or Compensation: The Case of Yield Spread Premiums*, 12 STAN J.L. BUS. & FIN. 289 (2007).

negative impressions with friends and family.⁴³ Although sales personnel may attempt to target uninformed consumers, such an approach can be risky as it may be hard to distinguish between informed and uninformed consumers. And even consumers that do end up purchasing inferior or over-priced products will often fail to discover this in the course of using their product.⁴⁴ Such consumers will not only hesitate before returning to the store, but they too may talk to family and friends about their negative experience.

To be sure, these market forces hardly eliminate sales contests and inducements that lead to slanted advice – there will always remain sleazy car salesmen, stores that sell over-priced and useless gadgets, and chains that push consumers to purchase over-priced accessories that add little to the overarching product. But the prospect that routine government intervention in these contexts could efficiently improve matters is slim. As this Section shows, these market forces that ordinarily protect consumers from excessive steering work poorly in consumer insurance markets.

i. *Information in Consumer Insurance Markets*

Unlike consumers in most markets, insurance consumers have access to few, if any, accurate measures of an insurer's reliability in paying claims fairly and efficiently.⁴⁵ It is, for instance, impossible for consumers to find out how often individual insurers pay claims within 30, 60, 90, or 120 days of a claim being reported; how frequently they deny claims; how frequently they are sued for payment or found guilty of bad faith; and how

⁴³ For a general discussion of the role of reputation in disciplining sellers' behavior, see Benjamin Klein & Keith Leffler, *The Role of Market Forces in Assuring Contractual Performance*, 89 J. POL. ECON. 615, 616 (1981).

⁴⁴ In economic parlance, insurance policies are thus "credence goods" because most consumers cannot evaluate their quality even after they purchase the policy. See Richard Craswell, *Interpreting Deceptive Advertising*, 65 B.U. L. REV. 657, 720-21 (1985) (explaining the differences between search goods, experience goods, and credence goods in economic and legal literature).

⁴⁵ "Information about the reliability of different insurers is hard to come by [and] the quality of insurance coverage is almost impossible to assess without an expert." KENNETH ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 176 (1986).

frequently policies are cancelled or non-renewed.⁴⁶ While consumers can look up how often complaints against specific insurers are lodged with state regulators, this data is notoriously unreliable and inconsistent.⁴⁷ Even the data published by *Consumer Reports* is highly limited, as it does not take into account the size and type of each consumer's claim and it is based on each consumer's subjective experience with the claims process.⁴⁸

Although consumers can, and do, carefully scrutinize premium differentials from different carriers, the significance of price differentials is almost impossible to assess without a corresponding understanding of the

⁴⁶ One recent proposal to the National Association of Insurance Commissioners (NAIC) would empower regulators to publicly disclose most of these data elements about the relative quality of insurers' claims handling, which they already collect. See PROPOSAL FOR CENTRALIZED DATA COLLECTION, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (Market Regulation Committee Proposal). Unfortunately, insurers have bitterly resisted the proposal under the guise of confidentiality and trade secrets. See Jim Connolly, *NAIC Insurer Conduct Data Scheme Riles Insurers*, NATIONAL UNDERWRITER, Sept. 25, 2008, available at <http://www.propertyandcasualtyinsurancenews.com/cms/nupc/Breaking%20News/2008/09/25-CONDUCTRULE-jc>; Chad Hemenway, *NCOIL Committee Votes Against NAIC Market Conduct Data Proposal*, BESTWIRE, Jul., 11 2008; Sean Carr, *NAIC Sets September Vote for Market Conduct Plan*, BESTWIRE, Jul. 28, 2008; Letter from Am. Health Ins. Plans, Am. Council of Life Insurers, Am. Ins. Ass'n, Blue Cross and Blue Shield Ass'n, Nat'l Ass'n of Mut. Ins. Cos., and Prop. Cas. Insurers Ass'n of Am. to Sandy Praeger, President of the Nat'l Ass'n of Ins. Comm'rs (May 27, 2008) available at http://www.naic.org/documents/committees_d_data_collection_comments_namic0527.pdf.

⁴⁷ See Daniel Schwarcz, *Redesigning Consumer Dispute Resolution: The American and British Approaches to Insurance Claims Conflict*, 83 TUL. L. REV. 735 (2009). Currently the Market Analysis and Priorities Working Group of the NAIC is working to develop better codes for the entire complaint data collection effort. See http://www.naic.org/committees_d_mapwg.htm (last visited February 8, 2009).

⁴⁸ Consumer Reports surveys thousands of consumers who filed claims and asks them to assess their satisfaction with the claims process. See *Consumer Reports Investigates, Surviving the Hard Market in Homeowners Insurance* Vol. 69, Issue 9, Consumer Reports, 36 (Sept. 2004); *Homeowners Insurance Report, The New Protection Game* Vol. 64, Issue 1, Consumer Reports, 16 (Jan. 1999).

differences in the underlying products.⁴⁹ A high-priced insurer may offer good coverage for a fair price, while a low-priced insurer may offer coverage that is poor, even relative to its seemingly low premiums. In fact, it is precisely for these reasons that independent agents choose to market themselves to consumers by focusing on their capacity to offer advice about competing carriers.

This lack of concrete information about the relative quality of different insurers undermines a key protection against aggressive steering in ordinary consumer markets. As described above, the fact that consumers ordinarily have the capacity to independently research and assess different product options limits the capacity of ordinary retail establishments to steer consumers to unfavorable deals. Moreover, it increases the prospect that attempting to do so will create market backlash, leading consumers who realize they are receiving poor advice to spread the word to others. But because most consumers simply do not have concrete information with which to assess the advice about the relative quality of carriers that insurance agents dispense, these protections are less robust in consumer insurance markets. This is particularly true given that insurance advice is hardly formulaic. The best insurance options for a customer may depend on numerous considerations, including the customer's risk tolerance, cash flow, preexisting relationships with carriers, and numerous other factors. This means self-serving advice can often be justified on some basis, and will rarely be obviously identifiable, even to experts.

Not only do consumers have a limited capacity to assess *ex ante* the quality of different carriers' coverage, but they also have a limited capacity to do so *ex post*. Unlike almost any other product, only a very small percentage of consumers end up using the insurance they purchase.⁵⁰ When they do, it is almost always for relatively small claims, even though the most important element of that insurance is the coverage it provides in cases of large losses.⁵¹ Finally, consumers that do submit claims to their insurers are typically ill-equipped to judge the extent to which their insurer

⁴⁹ Schwarcz, *Beyond Disclosure*, *supra* note 1, at 315.

⁵⁰ See Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389, 1413-15 (2007).

⁵¹ See *id.* at 1415.

lived up to its legal obligations.⁵² Consumers may therefore be susceptible to insurers' capacity to "tell a story" that appears to justify the refusal to pay a claim or a relatively low settlement of that claim.⁵³

This limitation in the capacity of consumers to assess insurance quality *ex post* further limits the power of market forces to address the steering that may result from differential compensation. Ordinarily, consumers who are successfully directed to inferior or overpriced products may discover this fact over time. Consumers who feel they were so victimized can not only choose to shop elsewhere in the future, but can talk to family and friends about their experience. Because most consumers who are steered to inferior insurance will never realize this fact, they will not exact these market penalties on agents who succumb to the temptation to maximize their compensation by directing consumers to inferior arrangements.

ii. *Consumer Decision-Making about Insurance*

In ordinary markets, consumers assess the desirability of different product options using a roughly rational process, at least in the aggregate. Especially when purchases involve big-ticket items, consumers are often willing to invest a significant amount of cognitive energy into making sure that they have thought through their options and selected a product that meets their needs and desires. As a result, salespeople can often exert only a minimal amount of pressure on shaping consumers' preferences. When salespeople push inferior or overpriced products, consumers may not only resist such practices, but may choose to avoid the establishment in the future and tell their friends and families of their experiences.

Two features of insurance markets substantially undermine this reasoned purchasing behavior, and the disciplining impact it has on agents' sales efforts. First, consumers typically purchase insurance as part of a larger event or transaction, such as taking a job, moving, or buying a home or automobile. Unlike with televisions, cars, or refrigerators, consumers do not typically decide that they can finally afford a new insurance policy, or

⁵² See Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1407-13 (1994).

⁵³ See *id.*

that their old policy is out of style, obsolete, or run down.⁵⁴ But the bundled decision-making that typifies such insurance purchases is both difficult and complicated, resulting in consumers “tend[ing] to adopt simpler choice strategies to cope with that complexity.”⁵⁵ Such simplistic strategies obviously enhance the capacity of sales agents to steer consumer decisions.

Second, empirical research has consistently demonstrated that consumers’ preferences concerning insurance are remarkably malleable.⁵⁶ Experimental research has established that framing effects can have important implications for consumers’ purchases of insurance policies. For instance, one study found that subjects were willing to pay more than twice as much for flight insurance covering “terrorism” and “mechanical failure” than they were willing to pay for flight insurance that would pay for losses for “any reason.”⁵⁷ Similarly, consumers tend to have bimodal responses to low-probability, high-cost risks, either dismissing them entirely or significantly overweighing their significance.⁵⁸ Which of these outcomes

⁵⁴ Evidence suggests that consumers rarely change carriers after they initially purchase a policy, especially outside of the auto insurance context. INSURANCE RESEARCH COUNCIL, PUBLIC ATTITUDE MONITOR 2001, Issue 2, at 5, fig. 2-3 (reporting that only 7% of homeowners or renters changed insurers in the last five years, but 23% of auto insurers did). When consumers do change insurers, they overwhelmingly cite price as the reason. *See id.* at 6, fig. 2-4.

⁵⁵ *See* Russel Korobkin, *Bounded Rationality, Standard Form Contracts, and Unconscionability*, 70 U. CHI. L. REV. 1203, 1223-34 (2003) (reviewing literature displaying this consumer tendency to choose simple choice strategies).

⁵⁶ Consumers’ decision-making processes about insurance are a complicated mix of intuitive, emotional, and rational responses that are susceptible to manipulation. *See* Howard Kunreuther & Mark Pauly, *Insurance Decision-Making and Market Behavior*, 1 FOUNDATIONS AND TRENDS IN MICROECONOMICS 63 (April 2005); David Cutler & Richard Zeckhauser, *Extending the Theory to Meet the Practice in Insurance*, Brookings-Wharton Papers on Financial Services (2004); PAUL SLOVIC, *THE PERCEPTION OF RISK* 76-77 (2000).

⁵⁷ Eric J. Johnson, et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35, 39 (1993).

⁵⁸ Gary H. McClelland, et al., *Insurance for Low Probability Hazards: A Bimodal Response to Unlikely Events*, 7 J. RISK & UNCERTAINTY 95, 104, 108-09 (1993).

obtains often depends on the availability of the underlying risk. Thus, Californians' purchases of earthquake insurance generally increase significantly immediately after an earthquake occurs and then gradually decrease (until the next earthquake).⁵⁹ Finally, consumers' insurance decisions are significantly impacted by their affection for the item to be insured. In general, people prefer to insure against losses that involve high affect, even when holding constant the expected value of the insurance and the insured's level of wealth.⁶⁰ It is for precisely these reasons that insurers are among the heaviest advertisers of any industry.⁶¹

Given this malleability of consumers' insurance preferences, experienced or well-trained sales agents are likely to have a substantial capacity to steer consumers to insurers by helping to shape those consumers' preferences. This form of steering is unlikely to generate any market backlash, because it involves altering consumers' preferences. Often, this manipulation unambiguously impedes efficient market outcomes by skewing consumer assessments of objective information. This occurs, for instance, with the framing of a risk to increase a consumer's assessment of its likelihood. At the same time, other types of manipulation may admittedly operate on consumer insurance preferences in ways that are normatively ambiguous.⁶² Consider an agent who focuses on a consumer's affection for an item in order to increase her desire to insure against loss to that item. Evaluating the desirability of this result within a consequentialist

⁵⁹ See Paul Slovic et al., *Preference for Insuring Against Probable Small Losses: Insurance Implications*, 44 J. RISK & INS. 237, 249, 252, 254-55 (1977); HOWARD KUNREUTHER, DISASTER INSURANCE PROTECTION: PUBLIC POLICY LESSONS 26-27, 36-41 (1978).

⁶⁰ Christopher K. Hsee & Howard C. Kunreuther, *The Affection Effect in Insurance Decisions*, 20 J. RISK & UNCERTAINTY 141, 142-43, 148 (2000). Entire markets for insurance have flourished based on this principle: consider life insurance for children, which in most cases is irrational based on standard insurance theory.

⁶¹ See Baker, *supra* note 52, at 1404.

⁶² See Brett H. McDonnell, *Endogenous Preferences and Welfare Evaluations*, 5-6, 9-12 (Oct. 18, 2006) (unpublished manuscript), available at: <http://ssrn.com/abstract=933089>.

framework is difficult (if not impossible), because there is no exogenously-defined preference to serve as a benchmark for that evaluation.⁶³

iii. *Insurance Agents' Discrimination Between Sophisticated and Unsophisticated Purchasers*

In any consumer market, plenty of consumers will be relatively uninformed and therefore susceptible to inefficient steering. But these uninformed consumers are typically protected by their more informed counterparts. Because aggressive or misleading sales efforts that are directed at informed and engaged consumers can have negative effects on a business's reputation, uninformed or rationally ignorant consumers often benefit from the presence of their more informed counterparts when sales people cannot distinguish between the two.⁶⁴

Once again, though, this market protection against inefficient steering is less robust in insurance markets. Unlike most salespeople, insurance agents must discuss clients' personal situations in order to assess their coverage needs and facilitate insurer underwriting.⁶⁵ This process enhances agents' capacity to assess the relative sophistication of their consumers, and to offer advice accordingly. In fact, one of the earliest studies of contingent commission payments found just such a pattern of discrimination in a large independent insurance agency in Arizona: relatively engaged customers were less frequently directed to insurers that paid contingent commissions than customers who were less engaged with their insurance purchases.⁶⁶ Such consumer segmentation undermines one

⁶³ See *id.* at 12, 18.

⁶⁴ Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 636-38 (1979).

⁶⁵ Schwarcz, *Beyond Disclosure*, *supra* note 1, at 318.

⁶⁶ *Id.* at 317-18; see Wilder, *supra* note 33, at 2-3, 5, 7. The agency, which remained unidentified, employed eight agents with no ownership stake in the company and three "equity agents" who received a portion of the agency's profits. Because the contingent commissions that the company received were paid directly to the company, the three equity agents stood to gain more from maximizing contingent commissions than the non-equity agents. Additionally, only the equity agents handled "house" accounts, which (1) either originated in another agency that

of the core protections against undue steering in ordinary markets: the capacity of an informed minority to protect the interests of other consumers.⁶⁷

B. THE COST OF MARKET FAILURE FOR DIFFERENTIAL COMMISSIONS

Market failures, of course, are ubiquitous. And many of these market failures are better left alone than subjected to the expensive, and often ineffective (or worse), forces of government regulation. But that is not the case here. This Section argues that insurers' payments of differential compensation to independent agents facilitate a "race to the bottom" in consumer insurance markets through insurer-side adverse selection.⁶⁸ They do so by undermining the willingness of independent agents to inform consumers about insurers' claims handling practices or to counteract consumers' tendency to discount the value of quality claims handling.

the company subsequently acquired or were originally handled by an agent who retired, and (2) did not fit the portfolio or expertise of any non-equity agent. The defining characteristics of these house accounts strongly suggest that they were less sensitive than other agency customers to the level of service they received from their agent. This hypothesis was corroborated by the fact that house accounts were three times more likely than other accounts to pay their premiums directly to their insurer, rather than to pay them through the agency, indicating disengagement with their insurance agent. The study concluded contingent commissions significantly impacted the recommendations that the equity agents gave to their less responsive consumers, finding that "the prospect of contingency fees [led] equity agents to increase the frequency with which they place house accounts with insurers offering contingent commissions by more than 50%." *Id.*

⁶⁷ See Schwarcz, *supra* note 50, at 1406-08; R. Ted Cruz & Jeffrey J. Hinck, *Not My Brother's Keeper: The Inability of an Informed Minority to Correct for Imperfect Information*, 47 HASTINGS L. J. 635, 672, 674-75 (1996).

⁶⁸ BAKER, *supra* note 9, at 7. Just as insurer's lack of information about consumers can lead to adverse selection, consumers' lack of information about insurers can lead to the "insurer-side" adverse selection described above.

i. Insurer-side Adverse Selection

Part A described how insurance consumers' limited information on the relative quality of different insurance options and suspect decision-making about insurance can lead ostensibly independent agents to steer consumers to inferior insurers. But these two market conditions can also have the more general impact of undermining competition among insurers with respect to claims handling.

If a sufficiently large percentage of consumers are ill-informed about insurers' claims handling, insurers that pursue aggressive claims handling strategies (lemons) will profit more than other insurers. These insurers can pass on some of these profits to consumers in the form of lower premiums. In the long run, this will force other insurers to either drop out of consumer markets or, more likely, adopt low quality claims handling practices themselves.⁶⁹ By contrast, if a sizable number of consumers are cognizant of differences in insurers' claims handling, then some insurers will seek to appeal to these consumers by adopting a high price, high quality brand. That, in turn, could force other market players to compete over their own claims handling quality. Of course, insurers' quality/price mix would still vary, with different insurers appealing to consumers with different risk preferences. As a result, the market as a whole would compete along both of the two primary dimensions that define the insurance-policyholder relationship.

Through similar mechanisms, insurer-side adverse selection can occur if insurance consumers' decision-making causes them to under-value, or under-appreciate, differences in insurers' claims handling practices. There are strong reasons to suspect consumer decision-making about insurance generally has this character.⁷⁰ The relative value to consumers of high quality insurance depends on two considerations: (i) the likelihood they will suffer a potentially insurable loss, and (ii) the likelihood a low-quality insurer will poorly handle any such claim relative to a high-quality insurer. With respect to the former, research has consistently found that most people judge their own likelihood of suffering a loss to be lower than

⁶⁹ See generally Hanson & Kysar, *supra* note 14, at 630, 722, 724-25, 746-47 (exploring how consumers' under-estimation of risks can compel a similar race to the bottom with respect to those risks).

⁷⁰ Indeed, research has consistently found that there is a "systematic tendency for insurance in practice to differ from insurance in theory." Cutler & Zeckhauser, *supra* note 56, at 3.

the average such risk, so long as they retain even a minimal amount of control over the event.⁷¹ Thus, people in general are overly optimistic about their risk of being injured in an earthquake,⁷² being involved in a car accident,⁷³ suffering health problems,⁷⁴ and dying young.⁷⁵ For these reasons, they also generally buy less insurance against these risks than they should, especially when no outside force – such as legal mandates or loan terms – artificially increases demand.⁷⁶

Although less evidence exists as to how consumers evaluate the likelihood that a low-quality insurer will poorly handle a claim relative to a high-quality insurer, there are theoretical reasons to believe people will also tend to under-estimate this risk differential. In part, that is because consumers' choice of insurers involves precisely the minimal amount of control over an ultimate risk (the risk of a low-quality choice having negative consequences) that leads people in other contexts to believe their

⁷¹ A separate relevant strand of research has found that, when facing low-probability risks, people tend to either dismiss those risks entirely or overweigh the value of insurance against those risks. See SLOVIC, *supra* note 56, at 75, 77; McClelland, *supra* note 58, at 95, 108-109. This conclusion, however, has ambiguous implications for the extent to which consumers believe they will suffer an insurable loss, depending on the side of the bimodal distribution on which an insured risk falls.

⁷² Jerry M. Burger & Michele L. Palmer, *Changes in and Generalization of Unrealistic Optimism Following Experiences with Stressful Events: Reactions to the 1989 California Earthquake*, 18 PERSONALITY & SOC. PSYCHOL. BULL. 39, 40-1 (1992).

⁷³ David Dunning et al., *Ambiguity and Self Evaluation: The Role of Idiosyncratic Trait Definitions in Self-Serving Assessments of Ability*, in HEURISTICS AND BIASES 324 (Thomas Gilovich et al., eds., Cambridge Univ. Press 2002); KUNREUTHER, *supra* note 59, at 240.

⁷⁴ Neil D. Weinstein, *Unrealistic Optimism About Future Life Events*, 39 J. PERSONALITY & SOC. PSYCHOL. 806, 807 (1980).

⁷⁵ See Kyle D. Logue, *The Current Life Insurance Crisis: How the Law Should Respond*, 32 CUMB. L. REV. 1, 2, 4, 23 (2001-2002).

⁷⁶ See *id.* (noting the vast majority of Americans are under-insured against the risk of dying young); KUNREUTHER, *supra* note 59 (suggesting most Californians do not purchase earthquake insurance).

risk is lower than the average such risk.⁷⁷ Additionally, however, the actual difference between low and high quality insurers is ambiguous, in that it involves numerous considerations that are hard to definitively compare across insurers, even with all relevant information.⁷⁸ Research suggests people tend to interpret such ambiguous information in self-serving ways.⁷⁹ Given that high quality insurance unambiguously costs more than low quality insurance, this bias may theoretically manifest itself in consumers dismissing potential differences in claims handling quality.

Of course, the mere fact that economic conditions in insurance markets could theoretically lead to insurer-side adverse selection does not make it so. But many consumer insurance markets do appear to be characterized by some degree of insurer-side adverse selection, with few insurers pursuing high-quality, high-price strategies. Aside from the common (though often anecdotal) observations of commentators acknowledging this equilibrium,⁸⁰ significant evidence suggests prominent national insurers such as Unum/Provident, State Farm, and Allstate have each recently engaged in systematic, national efforts to cut claims payments

⁷⁷ See *supra* text accompanying notes 71-76.

⁷⁸ See *supra* text accompanying notes 45-53.

⁷⁹ Linda Babcock & George Loewenstein, *Explaining Bargaining Impasse: The Role of Self-Serving Biases*, 11 J. ECON. PERSP. 109, 111 (1997).

⁸⁰ See, e.g., *Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000) (observing Blue Cross had "a financial interest in denying claims in order to remain economically viable as well as competitive within the insurance industry"); BAKER, *supra* note 9, at 128 (collecting specific examples of seeming insurer opportunism); Schwarcz, *supra* note 50, at 1401-26; John Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. L. REV. 1315, 1331 (2007) ("Even when insurance is experience rated, the insurer still has an incentive to deny claims, because the market for insurance services is intensely competitive. Low-cost providers prevail over high-cost providers."). But see Alan O. Sykes, "Bad Faith" Breach of Contract by First Party Insurers, 25 J. LEG. STUD. 405, 418 (1996) (arguing that "any insurer who frequently refused to pay covered claims would likely soon develop a reputation for behaving in this fashion and lose customers," but acknowledging that "it is plausible that insurers might occasionally behave opportunistically without suffering a prohibitive reputational penalty").

to policyholders.⁸¹ Additionally, the insurance industry plays a significant role in limiting public access to information about different insurers' claims handling quality. For instance, insurers have collectively devoted immense energy and resources to ensuring that data about their claims handling quality, which is already collected by state insurance regulators, is not made publicly available.⁸² Similarly, studies of insurer marketing and advertising suggest that individual insurers do not publicly advertise any *concrete* information about the quality of their claims handling, preferring instead vague and unverifiable promises about trust (as well as concrete promises about price, of course).⁸³ In a market where insurers sought to compete over the quality of their claims-handling, one would expect that some insurers would prominently resist these trends.

ii. *The Role of Differential Compensation in Explaining Insurers' Race to the Bottom*

As described above, the two economic conditions that make insurer side adverse selection a plausible, and seemingly accurate, description of consumer insurance markets are (i) consumer ignorance about claims handling quality and (ii) under-appreciation of the significance of this variable. This Section suggests that differential compensation of independent insurance intermediaries is a key contributor to this equilibrium.

Consumer markets are ordinarily able to overcome informational problems through the evolution of a network of independent intermediaries that digest complicated data and objectively present consumers with advice.⁸⁴ This process allows consumers to make informed choices that

⁸¹ See JEFFREY STEMPEL, LITIGATION ROAD: THE STORY OF CAMPBELL V. STATE FARM (2008) (displaying State Farm's practices); Langbein, *supra* note 80, at 1318-21 (displaying Unum/Provident's practices); Consumer Watchdog, *Consumer Advocates Call for Refunds, Rate Reductions, For Allstate Policyholders After Company Releases Internal Documents Revealing Intentionally Underpaid Customers*, REUTERS, Apr. 7, 2008 (displaying Allstate's practices), available at <http://www.reuters.com/article/pressRelease/idUS187467+07-Apr-2008+PRN20080407>.

⁸² See documents cited *supra* note 46.

⁸³ See generally Baker, *supra* note 52.

⁸⁴ See Thomas F. Cotter, *Some Observations on the Law and Economics of Middlemen*, 1 MICH. ST. L. REV. 67, 69-70 (2006) (describing several economic

reflect their risk preferences despite their relative lack of understanding about the underlying market. Just as importantly, it improves the decision-making of less sophisticated consumers, by influencing insurers' reputations through word-of-mouth among consumers.⁸⁵

In the insurance context, objective and independent market intermediaries could accomplish these ends by digesting data on claims handling quality, along with repeated first-hand observation of insurers' practices, to accurately communicate information about insurers' claims handling practices. Such information gathering services are particularly significant in consumer insurance markets, not simply because of the dearth of public information on insurers' claims handling practices,⁸⁶ but also because few consumers could independently assess such information, even if it were publicly available. The quality of an insurer's claims handling is not a monolithic concept, and could be constructed in multiple ways, with differences in metrics appearing significant when they were not, or *vice versa*. For instance, data suggesting an insurer denied a relatively high percentage of claims, or a relatively high number of its consumers sue for coverage or complain to state regulators, might simply reflect the insurer's pool of policyholders, rather than its claims handling practices.⁸⁷

roles for middlemen, including assisting "consumers by reducing the cost of product search and evaluation, helping consumers to find the products that best fit their needs, and helping consumers to manage risk.").

⁸⁵ This role of market intermediaries in filtering and processing information for less sophisticated parties has been extensively discussed in debates on the efficient capital markets hypothesis, which is often imagined to achieve efficiency through a similar market intermediation mechanism. *See generally* Susanna Kim Ripken, *Predictions, Projections, and Precautions: Conveying Cautionary Warnings in Corporate Forward Looking Statements*, 2005 U. ILL. L. REV. 929 (2005) (discussing the role of market intermediaries in the efficient capital markets hypothesis).

⁸⁶ *See supra* Part II.A.

⁸⁷ Insurers have themselves seized on these difficulties in assessing claims handling data as one of their primary arguments against public disclosure. *See* Letter from Wiley Rein to Sandy Praeger, Pres. of the Nat'l Ass'n of Ins. Comm'rs 6 (April 16, 2008), *available at* http://www.naic.org/documents/committees_d_data_collection_comments_namic0416.pdf (resisting the public release of market conduct regulation, because "release of the information in raw form without the benefit of evaluation and interpretation would be unfair and potentially

Just as independent and objective sales agents can improve consumer information, they can also improve consumers' capacity to rationally and thoughtfully assess the trade-offs associated with purchasing relatively high quality insurance. By employing "debiasing" strategies, intermediaries may be able to counteract the tendency of consumers to under-appreciate the value of high quality coverage.⁸⁸ For instance, research suggests that people who are convinced that a potential loss is truly random generally no longer perceive they are relatively less likely than average to suffer from those losses.⁸⁹ By pointing out just how little control people have over the financial losses that are the subject of insurance, independent intermediaries could convince consumers to pay more for more reliable coverage. Similarly, independent agents might be able to concretize information about insurers' relative claims handling, thereby limiting the ambiguity of risk differentials that can trigger a self-serving interpretation of information. Even if independent intermediaries could not neutralize these biases, they might be able to counteract them.⁹⁰ For instance, independent agents could attempt to enhance consumers' evaluations of the risks attendant to low quality coverage by vividly describing these risks. Increasing the availability of risks can counteract consumers' tendency to underestimate them.⁹¹

Differential compensation undermines these market intermediation mechanisms by distorting the objectivity of the advice independent

damaging to insurers, and misleading to policyholders, investors, and the public at large.").

⁸⁸ See Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. LEGAL STUD. 199, 204-05 (2006).

⁸⁹ Colin Camerer & Dan Lovallo, *Overconfidence and Excess Entry: An Experimental Approach*, 89 AM. ECON. REV. 306, 307 (1999); David Dunning, Chip Heath & Jerry M. Suls, *Flawed Self-Assessments: Implications for Health, Education, and the Workplace*, 5 PSYCH. SCI. PUB. INTEREST 69, 80 (2004) ("One of the strongest moderators of unrealistic optimism is perceived control. The greater a person's perceived control over an event or its outcome, the stronger the person's optimistic bias.").

⁹⁰ See Johnson et al., *supra* note 57, at 48. ("[C]onsumers' decisions about insurance can be affected by distortions in their perceptions of risk and by alternative framing of premium and benefits.").

⁹¹ Jolls & Sunstein, *supra* note 88.

insurance agents offer to consumers.⁹² Agents' capacity to mitigate consumer ignorance about insurance and debias consumers in ways that promote thoughtful consideration of insurance quality depends on agents prioritizing the interests of those clients. When intermediaries are incentivized to steer consumers to insurers in order to maximize their compensation, they are also encouraged to manipulate consumer preferences and impressions to achieve this outcome. This short-circuits the ordinary market solutions to informational and decision making problems in complex consumer markets. As a result, even insurers that are interested in cultivating a high-price, high-quality market strategy have limited vehicles for effectively communicating this strategy to potentially interested consumers. This creates circumstances under which insurer-side adverse selection with respect to claims handling can (and seemingly does) flourish.

III. CRAFTING AN EFFECTIVE RESPONSE TO DIFFERENTIAL COMPENSATION

Given the need for reform described in Part II, this Part briefly concludes by considering a simple legal intervention in insurance markets that resembles measures adopted in the federally-regulated markets that relate to Medicare.⁹³ That reform would limit insurer compensation of independent agents selling consumer lines of coverage to premium-based commissions, and would require insurers to pay a single, flat commission rate to all independent agents in their distribution networks. It would not mandate any particular commission rate, allowing insurers to choose the rate they wanted to offer to their independent agents. Insurers could set different premium commission rates for different lines of insurance, reflecting the fact that different product lines require different levels of effort for agents. Additionally, insurers could pay different commission rates to independent agents in different states to account for premium and cost of living differences across states.

Such reform would largely eliminate the distorting potential of differential compensation, leaving independent intermediaries without significant financial reasons to promote the policies of one insurer over another. Although some insurers might offer slightly higher commission rates than others, competition would ensure that these differentials would

⁹² See Section II.A, *supra*.

⁹³ See Press Release, *supra* note 15.

generally be quite small.⁹⁴ To the extent that differentials in commission rates persisted, they would be much less problematic than current commission differentials. Rather than rewarding individual preferred agents who steered consumers to a particular insurer, they would reflect an insurer's decision to offer above market commissions to all independent agents who sell a particular product line. As noted earlier, such a strategy might be justifiable for new entrants in a market seeking to establish a customer base.⁹⁵ Moreover, a high commission strategy might also be sensible for insurers offering high-price, high-quality products if the sale of such products requires comparatively more effort. Indeed, some economics literature suggests that sales agents in the consumer electronics industry may receive higher commission rates, on a per-dollar basis, for the sale of high quality products than low quality products for this reason.⁹⁶

Not only would a flat compensation rate for an insurer's independent agents help to solve the problems identified in Part II, but it would do so while imposing few administrative costs. A ban on contingent commissions or other specific compensation arrangements, standing alone, only invites insurers to design compensation structures that retain the same basic incentivizing function, but technically comply with the ban. Insurers' switch from contingent commissions to "supplemental compensation" arrangements, which retain the same performance-based contingency structure, is illustrative.⁹⁷ Because of its simplicity, a mandatory flat rate of

⁹⁴ Tacit collusion among insurers in setting commission rates would be unlikely, given the number of insurers who rely on independent agents to distribute their products.

⁹⁵ See *supra* text accompanying note 29 (noting that this was one reason historically that insurers offered higher premium commission rates).

⁹⁶ See Ajay Kalra, Mengze Shi, Kannan Srinivasan, *Salesforce Compensation Scheme and Consumer Inference*, 655 *Management Science* (2003).

⁹⁷ See Sally Roberts, *Compensation Shake-Up Continues; Chubb Pays \$17M, Ends All Contingents*, BUS. INS., Dec. 25, 2006 (noting that the Chubb agreement states that "a fixed commission paid to a producer, set prior to the sale of a particular insurance product, and that may be based on, among other things, the prior year's performance of the producer' is not considered contingent"). Although some have suggested that these newly-emerging arrangements avoid the conflicts of interest associated with contingent commissions because they are "retrospective rather than prospective," this argument is unpersuasive. The fact that supplemental compensation arrangements are retrospective merely shifts

compensation for all intermediaries avoids this inefficient gaming. Moreover, it would be easy to enforce because it would operate on insurers rather than intermediaries. There are obviously fewer insurers than intermediaries (making market conduct observation easier) and insurers are less likely to engage in outright fraud than individual intermediaries who have less to lose from doing so.

Of course, mandating that insurers pay their independent agents a single commission rate is significantly more intrusive than a disclosure-based response to the problem. Not only would it be more costly to employ than disclosure, but it might distort consumer insurance markets in ways that may be hard to measure, or even predict. Nonetheless, such an aggressive intervention is prudent.

First, merely enhancing the disclosure requirements of independent agents is unlikely to mitigate the risk of steering, and the attendant risks of insurer-side adverse selection. Although I develop the limits of a disclosure-based regulatory response elsewhere,⁹⁸ the basic argument is simple: as described above, the reason that market forces do not prevent inefficient steering is that consumers generally have a limited ability to independently assess their insurance options. Merely informing consumers that their intermediaries may have a conflict of interest does nothing to address this fact. Of course, such disclosure could facilitate an agent's capacity to eschew differential compensation as a marketing technique.⁹⁹ But such efforts would be unlikely to prove profitable because consumers would have little sense of the value of such neutrality.

It is for precisely these reasons that compensation practices in consumer insurance markets have not, in fact, changed since 2004, despite the very public revelation of agents' conflicts of interest at that time and the adoption of mandatory disclosure laws in a number of states since.¹⁰⁰ This is particularly noteworthy given that numerous intermediaries in commercial insurance markets have voluntarily disclaimed differential

forward the potential pay-off to intermediaries of steering customers to sub-optimal insurance. See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 292.

⁹⁸ Schwarcz, *Beyond Disclosure*, *supra* note 1.

⁹⁹ As noted above, this is precisely what has happened in commercial insurance markets.

¹⁰⁰ See Fitzpatrick, *supra* note 1, at 3064; Cooper, *supra* note 8, at 100.

compensation to recruit and retain new clients.¹⁰¹ Simply put, if potential clients are not attuned to the importance of unbiased advice or the ways in which advice can be distorted by incentive structures, they will not be swayed to change their behavior by competitors' promises of neutrality.

In fact, regulations of structurally similar conflicts of interest in other industries have often gone beyond disclosure-based strategies for precisely these reasons. Differential compensation of insurance intermediaries is one form of a common type of regulatory problem, coined a "trilateral dilemma."¹⁰² In a trilateral dilemma, an end-service provider compensates a market intermediary in order to induce the intermediary to steer consumers' business to the end-service provider.¹⁰³ Regulations of such side payments often do more than merely require disclosure, for the precise reasons developed above. Examples include prohibitions against certain side payments to real estate settlement providers,¹⁰⁴ limitations on side payments that brokerage firms can pay to investment managers,¹⁰⁵ and limitations on attorneys' receipts of side-payments for referrals to other attorneys.¹⁰⁶

Second, none of the proposed economic rationales for differential compensation appreciably enhance the efficiency of consumer insurance markets.¹⁰⁷ The most significant such potential benefit of differential

¹⁰¹ See *supra* text accompanying note 3.

¹⁰² See Schwarcz, *Beyond Disclosure*, *supra* note 1, at 312-19; Jackson, *supra* note 42.

¹⁰³ Jackson, *supra* note 42..

¹⁰⁴ See 12 U.S.C. § 2607 (2006).

¹⁰⁵ See D. Bruce Johnsen, *Property Rights to Investment Research: The Agency Costs to Soft Dollar Brokerage*, 11 YALE J. ON REG. 75, 82-83 (1994); see also 15 U.S.C. § 78b (2008).

¹⁰⁶ See Model Rules of Prof'l Conduct R. 7.2(b) (2009).

¹⁰⁷ Aside from the enhanced underwriting theory addressed in the text, contingent commissions have also been defended because they: (i) may expand coverage for non-verifiable losses, Neil A. Doherty & Alexander Muermann, *Insuring the Uninsurable: Brokers and Incomplete Insurance Contracts* 18 (Ctr. for Fin. Studies, Working Paper Nov. 24, 2005) available at http://www.ifk-cfs.de/papers/05_24.pdf; (ii) protect small agencies, Fitzpatrick, *supra* note 1, at 3042; and (iii) facilitate economies of scale by encouraging intermediaries to work

compensation is that it can improve the “front-line underwriting” of independent agents by giving them a stake in insurers’ profitability.¹⁰⁸ According to this theory, agents often possess information about the riskiness of customers that insurers cannot directly observe, as they interact directly with their customers and may have long standing relationships with them. Differential compensation that is linked to insurer profitability gives agents an economic reason to convey truthful information to the insurer. Alternatively, such compensation may facilitate improved underwriting simply by causing an agent who believes that a consumer is a “bad risk” to steer that consumer to a different insurer that does not pay differential commissions.

Whatever purchase this theory may have in commercial insurance markets, it is simply implausible in the context of consumer insurance lines. The theory assumes agents do indeed have important underwriting information about their clients that insurers cannot observe directly. But insurer underwriting in consumer insurance markets is generally standardized and based on simple and easily administrable algorithms.¹⁰⁹ Even if independent agents did possess information that could not be captured in an insurance application, it is unlikely that insurers would find

with fewer insurers, Cummins & Doherty, *supra*, note 4, at 386-89. For reasons developed in Schwarcz, *Beyond Disclosure*, *supra* note 1, at 305-11, these justifications are not persuasive. A final defense of contingent commissions – that they help small insurers to break into the market – is not in conflict with the proposal suggested herein, which would permit insurers to offer above-market premium commission rates.

¹⁰⁸ Cummins & Doherty, *supra* note 4, at 386-89; *see also* Regan & Tennyson, *supra* note 20, at 639 (“The agent is the first contact the insurer has with a potential policyholder and may be able to obtain information about the customer which would be difficult or costly for the firm to verify. It is widely acknowledged that agents often employ subjective criteria in evaluating insurance applicants.”).

¹⁰⁹ *See* ABRAHAM, DISTRIBUTING RISK, *supra* note 45, at 78 (“[A]n efficient classification system does not strive to make its premiums equal expected costs beyond the point where that goal is worth achieving.”). RICHARD V. ERICKSON, AARON DOYLE & DEAN BARRY, INSURANCE AS GOVERNANCE 241 (2003) (“Individual companies are increasingly less likely to undertake their own home inspection or direct field investigations of an applicant. Instead, more risk assessment is centralizing into data system operated by information service companies that supply the insurance industry.”).

incorporating that information into their underwriting to be cost efficient.¹¹⁰ This is especially true given the lack of adverse selection in most consumer insurance markets.¹¹¹

Of course insurance markets, like all markets, change over time. Thus, rationales for differential compensation that may not be compelling now may prove significant later. Consequently, any market intervention should be accompanied with continued monitoring and supervision. But the need for continuous re-assessment does not absolve lawmakers from ignoring conflicts of interest in consumer insurance markets that have been addressed in commercial and federally-regulated insurance markets. The failure of state lawmakers to act not only undermines the efficiency of consumer insurance markets, but it blunts the claim that consumer protection is best secured through the continuation of state-based insurance regulation.¹¹²

¹¹⁰ See H. LAURENCE ROSS, SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENTS 135 (1970) (explaining how insurers must adopt easily administrable rules of thumb to operate effectively).

¹¹¹ See Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1224-5 (2004).

¹¹² See, e.g., Press Release, NAIC Still in Opposition to Federal Regulation (Jan. 20, 2009) (On file with the National Association of Insurance Commissioners).

